IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– 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

February 28, 2018

Heather Thomas, Administrator
Canyon Home Care & Hospice
929 NW 16th Street
Fruitland, ID 83619-2256

RE: Canyon Home Care & Hospice, Provider #137068

Dear Ms. Thomas:

On February 23, 2018, a follow-up visit of your facility, Canyon Home Care & Hospice, was conducted to verify corrections of deficiencies noted during the survey of December 1, 2017.

We were able to determine that the Conditions of Participation of **Organization, Services and Administration (42 CFR 484.14), Acceptance of Patients, Plan of Care and Medical Supervision (42 CFR 484.18), Skilled Nursing Services (42 CFR 484.30), Medical Social Services (42 CFR 484.34) and Home Health Aide Services (42 CFR 484.36)** are now met.

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

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;

- Monitoring and tracking procedures to ensure the PoC is effective in bringing the Home Health Agency into compliance, and that the Home Health Agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567 and State Form 2567.

After you have completed your Plan of Correction, return the original to this office by **March 13, 2018**, and keep a copy for your records.

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

DENNIS KELLY. RN, Supervisor
Non-Long Term Care

DK/pmt
Enclosures

ec: Patrick Thrift, Survey & Certification Manager Region X
Julius Bunch, Certification & Enforcement Manager Region X

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001080	A. BUILDING: _____ B. WING _____	R 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON HOME CARE & HOSPICE	929 NW 16TH STREET FRUITLAND, ID 83619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	INITIAL COMMENTS The following deficiencies were cited during a follow-up to a State licensure survey of your home health agency from 2/20/18 through 2/23/18. The surveyors conducting the follow-up State licensure survey were: Teresa Hamblin, RN, MS, HFS, Team Leader Gary Guiles, RN, HFS	N 000	Please see the attached Plan of Correction	3.14.18
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 G 144 as it relates to a failure of the agency to ensure documentation of coordination of patient care.	N 062	Please see the attached Plan of Correction G 144 RECEIVED MAR 19 2018 FACILITY STANDARDS	3.14.18
N 091	03.07024. SK.NSG.SERV. N091. The HHA furnishes nursing services by or under the supervision of a registered nurse in accordance with the plan of care. This Rule is not met as evidenced by: Refer to G 170 as it relates to the failure of the	N 091	Please see the attached Plan of Correction G170	3.14.18

Bureau of Facility Standards

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N 091	Continued From page 1 agency to ensure a registered nurse provided care in accordance with the plan of care.	N 091	Please see the attached Plan of Correction G170	3.14.18
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 G 173 as it relates to the failure of the agency to ensure the registered nurse made necessary revisions to the plan of care.	N 094	Please see the attached Plan of Correction G173	3.14.18
N 105	03.07024. SK. NSG. SERV. N105 02. Licensed Practical Nurse. A licensed practical nurse perform the following: c. Prepares equipment and materials for treatments observing aseptic technique as required; This Rule is not met as evidenced by: Refer to G 182 as it relates to the failure of the agency to ensure the LPN maintained aseptic technique.	N 105	Please see the attached Plan of Correction G182	3.14.18
N 122	03.07024.SK.NSG.SERV. N122 05. Training, Assignment and	N 122	Please see the attached Plan of Correction G 224	3.14.18

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N 122	Continued From page 2 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: Refer to G 224 as it relates to ensure the registered nurse prepared complete written instructions for the home health aide.	N 122	Please see the attached Plan of Correction G 224	3.14.18
N 153	03.07030.PLAN OF CARE N153 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: a. All pertinent diagnoses; This Rule is not met as evidenced by: Refer to G 159 as it relates to the failure of the agency to ensure all pertinent diagnoses were included on the plan of care.	N 153	Please see the attached Plan of Correction G159	3.14.18
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	N 173	Please see the attached Plan of Correction G337	3.14.18

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N 173	Continued From page 3 all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G 337 as it relates to the failure of the agency to ensure a medication list was kept current and a medication discrepancy was reported to the physician.	N 173	Please see the attached Plan of Correction G 337	3.14.18

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{G 000}	INITIAL COMMENTS The following deficiencies were cited during a follow-up to a Medicare recertification survey of your home health agency from 2/20/18 through 2/23/18. The surveyors conducting the follow-up to the recertification survey were: Teresa Hamblin, RN, MS, HFS, Team Leader Gary Guiles, RN, HFS Acronyms used in this report include: CHF - Congestive Heart Failure COPD - Chronic Obstructive Pulmonary Disease DME - Durable Medical Equipment LPN - Licensed Practical Nurse HFS - Health Facility Surveyor mg - milligram OT - Occupational Therapy PA - Physician Assistant POC - Plan of Care PRN - As Needed PT - Physical Therapy RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care 24h - 24 hours	{G 000}	RECEIVED MAR 13 2018 FACILITY STANDARDS RECEIVED MAR 13 2018 DIV. OF MEDICAID 4:50 pm SF	
{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.	{G 144}	Please see the attached Plan of Correction	3.14.18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3.13.18

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 144}	Continued From page 1 This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the agency failed to ensure documentation of coordination of care occurred for 2 of 8 patients (#2 and #5) whose records were reviewed. This interfered with the ability of agency personnel to address patient needs. Findings include: 1. Patient #2 was a 96 year old male, who was admitted on 1/16/18, for pulmonary problems, cardiac problems, and non insulin dependent diabetes. He was currently a patient as of 2/23/18. He lived alone in a trailer approximately 60 feet across a gravel drive from his child's house. A "Skilled Nursing Visit Note" by the LPN, dated 2/19/18 at 4:57 PM, stated Patient #2 did not take enough pain medication to control his pain, especially in the morning. The note stated Patient #2's pain was 10 out of 10 in the morning. The note also stated Patient #2 had a history of crushed vertebra and he complained his legs did not want to work in the morning. The note said Patient #2 stated he was lonely in the trailer where he was by himself most of the day. It said Patient #2 stated he could hardly make it over to the house for meals. The note stated Patient #2 cried as he was telling this to the nurse. The note did not state the LPN communicated this information with Patient #2's case Manager. The LPN, who wrote the 2/19/18 note, was interviewed on 2/23/18 beginning at 9:00 AM. The LPN stated she thought she informed the Case Manager of Patient #2's pain and other issues but she said this was not documented.	{G 144}	Please see the attached Plan of Correction	3.14.18

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{G 144}	Continued From page 2 The LPN failed to document coordination with Patient #2's Case Manager. 2. Patient #5 was a 38 year old female, who was admitted on 1/26/18, for care following total knee surgery. She was currently a patient as of 2/23/18. A "Skilled Nursing Visit Note" by the LPN, dated 1/31/18 but not timed, stated Patient #5 reported "Excruciating" leg pain at 9 of 10 on a pain scale. No further assessment of her pain was documented. No action to relieve Patient #5's pain was documented. The note stated the LPN's "Supervisor" was contacted but it did not state what was discussed. The note also stated Patient #5 was alert and oriented, her vital signs were within normal limits, and there were no new issues to report. The LPN, who wrote the 1/31/18 note, was interviewed on 2/23/18 beginning at 10:40 AM. The LPN stated she did not remember this particular interaction with Patient #5. She stated she spoke with the Case Manager almost every day at the end of her shift. She confirmed the record did not state whether she notified the Case Manager of Patient #5's pain. The LPN failed to document coordination with Patient #5's Case Manager.	{G 144}	Please see the attached Plan of Correction	3.14.18
{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 equipment required, frequency of visits,	{G 159}	Please see the attached Plan of Correction	3.14.18

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{G 159}	Continued From page 3 prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on record review, policy review, observation, and staff interview, it was determined the agency failed to ensure the plan of care covered all relevant diagnoses, supplies, DME, or safety measures for 4 of 8 patients (#1, #2, #4, and #6) whose records were reviewed. This resulted in incomplete plans of care and had the potential to interfere with quality of patient care. Findings include: Agency policy 0-05, "PLAN OF CARE," revised 12/27/17, included the expectation the plan of care included primary and secondary diagnoses, medical equipment and supplies, and safety measures to protect against injury. This policy was not followed. Examples include: 1. Patient #4 was a 72 year old female, admitted to the agency on 2/01/18, for care following neck surgery. Diagnoses included spinal stenosis in the cervical region, muscle weakness, abnormalities of gait and mobility, and CHF. She received SN, PT, and OT services. Her record, including the POC for certification period 2/01/18 to 4/01/18, was reviewed. a. The "Intake Record," dated 1/20/18, included Patient #4's referral information. It documented COPD as a primary diagnosis for Patient #4. The	{G 159}	Please see the attached Plan of Correction	3.14.18

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{G 159}	Continued From page 4 diagnosis was not included in Patient #4's POC. b. The initial SOC assessment, dated 2/01/18, signed by the RN Case Manager, stated Patient #4 had a "necklace alert (too heavy for neck d/t [due to] pain) placed on table within hands reach for emergency call." The necklace alert was not included on Patient #4's POC as a relevant safety measure or supply. During an interview on 2/22/18 at 2:30 PM, the Compliance Director reviewed Patient #4's record and confirmed the diagnosis of COPD and the Life Alert necklace were missing from the POC. Patient #4's POC was missing a relevant diagnosis and safety measure, and therefore incomplete. 2. Patient #6 was an 88 year old male admitted to the agency on 1/31/18, with a primary diagnosis of COPD. Additional diagnoses included cirrhosis of the liver, pressure ulcer, and generalized muscle weakness. He received SN, PT, OT, and aide services. His record, including the POC for certification period 1/31/18 to 3/31/18 was reviewed. The initial SOC assessment, dated 1/31/18, signed by the RN Case Manager, documented urinary incontinence managed with use of incontinence briefs and pads. The POC, dated 1/31/18, did not include incontinence briefs or pads as relevant supplies for Patient #6. During an interview on 2/22/18 at 2:15 PM, the Compliance Director reviewed Patient #6's record	{G 159}	Please see the attached Plan of Correction	3.14.18

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{G 159}	Continued From page 5 and confirmed the incontinent supplies were not included on Patient #6's POC. Patient #6's POC was missing relevant supplies, and therefore incomplete. 3. Patient #1 was a 68 year old female admitted to the agency on 1/19/18, with a primary diagnosis of a fracture in the cervical region. Additional diagnoses included right rib fractures, abnormality of gait. She received, SN, PT, and aide services. Her record, including the POC for the certification period 1/19/18 to 3/19/18, was reviewed. During a home visit on 2/21/18 at 11:00 AM, Patient #1 was observed to be wearing a life alert device around her neck. She stated she used it as a safety measure in case she fell and no-one was around to help her up, which had occurred on more than one occasion. During an interview on 2/22/18 at 1:30 PM, the Compliance Director confirmed the POC did not include the Life Alert device as a safety measure or supply. Patient #1's POC was missing a relevant safety measure and/or supply, and therefore incomplete. 4. Patient #2 was a 96 year old male, who was admitted on 1/16/18, for pulmonary problems, cardiac problems, and non insulin dependent diabetes. He was currently a patient as of 2/23/18. He lived alone in a trailer approximately 60 feet across a gravel drive from his child's house.	{G 159}	Please see the attached Plan of Correction	3.14.18

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{G 159}	Continued From page 6 Patient #2's POC, for the certification period 1/06/18 to 3/06/18, included the diagnosis "Type 2 diabetes mellitus [with] chronic kidney disease." The POC stated he took an oral hypoglycemic medication for his diabetes. Otherwise, the POC did not address Patient #2's diabetes. The POC did not mention blood sugar testing or levels where the physician should be notified. Patient #2's "Skilled Nursing Care Plan," dated 1/06/18, noted diabetes as a problem. The plan listed teaching foot care and assessing his skin. No other direction to staff regarding diabetes was documented in either POC. The American Diabetes Association website, reviewed on 2/26/18, listed a blood sugar target range of less than 180 for diabetic patients after a meal. The target range for persons with diabetes before a meal was 80-130. A "Skilled Nursing Visit Note" by the RN, dated 2/03/18 but not timed, stated Patient #2 had not remembered to check his blood sugar level "...for the past couple of days." However, a level was not documented for that day. A "Skilled Nursing Visit Note" by the LPN, dated 2/05/18 but not timed, stated Patient #2's blood sugar level was 202. The note did not state whether this was before or after eating. The note stated "Blood sugar results within expected/normal range." The note did not state what the "expected/normal range" was or how it was determined. A "Skilled Nursing Visit Note" by the RN, dated 2/13/18 but not timed, stated Patient #2's blood sugar level at 10:30 AM, after breakfast, was 363. The note stated Patient #2 did not check his sugar level before breakfast. The note did not state his physician was notified of the elevated blood sugar	{G 159}	Please see the attached Plan of Correction	3.14.18

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{G 159}	Continued From page 7 level. During a visit to Patient #2's home, on 2/21/18 beginning at 1:00 PM, the surveyor observed a calendar that Patient #2 used to write down his blood sugar levels. Only 4 blood sugar levels were documented on the calendar for February 2018. Patient #2's LPN was interviewed on 2/23/18 beginning at 9:00 AM. The LPN confirmed the above documentation from the medical record and stated the POC did not direct staff when to notify the physician depending on Patient #2's sugar levels. The LPN also stated the POC did not address monitoring Patient #2's blood sugar levels. Patient #2's POC did not adequately address diabetic monitoring.	{G 159}	Please see the attached Plan of Correction	3.14.18
{G 170}	SKILLED NURSING SERVICES CFR(s): 484.30 The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on policy review, record review, and staff interview, it was determined the agency failed to ensure SN POC was followed for 1 of 8 patients (Patient #4) whose records were reviewed. This resulted in a patient with CHF not having her weight monitored. It had the potential to result in significant findings being missed and reported to the physician. Findings include: Agency policy N-01, "NURSING SERVICES,"	{G 170}	Please see the attached Plan of Correction	3.14.18

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{G 170}	Continued From page 8 revised 12/30/17, stated licensed nurses would "perform nursing care according to the needs of the patient and as indicated in the written Plan of Care." This policy was not followed. An example includes: Patient #4 was a 72 year old female, admitted to the agency on 2/01/18, for care related to neck surgery. Diagnoses included spinal stenosis in the cervical region, muscle weakness, abnormalities of gait and mobility, and CHF. She received SN, PT, and OT services. Her record, including the POC for certification period 2/01/18 to 4/01/18, was reviewed. Patient #4's POC, dated 2/01/18, included a diagnosis of CHF and an intervention for SN to "Assess weight change." The initial SOC assessment, dated 2/01/18, signed by the RN Case Manager, documented Patient #4's initial weight as 128. Subsequent SN visit notes, dated 2/05/18, 2/08/18, and 2/13/18, did not include weights. During an interview on 2/22/18 at 2:30 PM, the Compliance Director reviewed Patient #4's record and confirmed the weights were missing. Weights were not assessed for Patient #4 in accordance with the plan of care.	{G 170}	Please see the attached Plan of Correction	3.14.18
{G 173}	DUTIES OF THE REGISTERED NURSE CFR(s): 484.30(a) The registered nurse initiates the plan of care and necessary revisions.	{G 173}	Please see the attached Plan of Correction	3.14.18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137068	A. BUILDING _____ B. WING _____	R 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{G 173}	Continued From page 9 This STANDARD is not met as evidenced by: Based on staff interview, policy review, and medical record review, it was determined the agency failed to ensure the RN made necessary revisions to the POC for 1 of 8 patients (Patient #3) whose records were reviewed. This resulted in a medication list and POC that did not reflect a newly prescribed medication. Findings include: Agency policy N-01, "NURSING SERVICES," revised 12/30/17, stated a registered nurse shall "Initiate the Plan of Care and make necessary revisions." Agency policy N-24, "MEDICATION MANAGEMENT," revised 12/30/17, stated "medication lists are to be updated for each change to reflect current medications, new and/or discontinued medications." These policies were not followed. Examples include: Patient #3 was a 70 year old female admitted to the agency on 12/29/17, with a primary diagnosis of hypertensive chronic kidney disease. Additional diagnoses included abnormalities of gait and mobility, and generalized muscle weakness. She received SN services. Her record, including the POC for certification period 12/29/17 to 2/26/18, was reviewed. An RN visit note, dated 2/08/18, indicated Patient #3 was referred to an urgent care center due to "greenish slough" observed on a blister on her left lower leg.	{G 173}	Please see the attached Plan of Correction	3.14.18

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{G 173}	Continued From page 10 A visit note from the urgent care center, dated 2/08/18, and included in Patient #3's home health record, stated a PA ordered "Clindamycin antibiotic" for Patient #3. The RN did not make necessary revisions to Patient #3's POC/medication list. An RN visit note, dated 2/10/18, referenced "client is on antibiotic every 6 hours for 7 days." Patient #3's POC and medication list were not updated to reflect the new medication. During an interview on 2/22/18 at 1:45 PM, the Compliance Officer reviewed Patient #3's record and confirmed Patient #3's POC and medication list were not updated to include the Clindamycin ordered by the PA at the urgent care center.	{G 173}	Please see the attached Plan of Correction	3.14.18
G 182	DUTIES OF THE LICENSED PRACTICAL NURSE CFR(s): 484.30(b) The licensed practical nurse prepares equipment and materials for treatments, observing aseptic technique as required. This STANDARD is not met as evidenced by: Based on observation, policy review, record review, and staff interview, it was determined the LPN failed to maintain aseptic technique for 1 of 1 patients (Patient #3) whose wound care was observed in the home. This has the potential to increase the risk of infection. Findings include: Agency policy I-08, "HANDWASHING" (undated), included the expectation staff would wash their	G 182	Please see the attached Plan of Correction	3.14.18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 182	Continued From page 11 hands "before and after gloves are used or in between glove changes..." This policy was not followed. An example includes: Patient #3 was a 70 year old female admitted to the agency on 12/29/17, with a primary diagnosis of hypertensive chronic kidney disease. Additional diagnoses included abnormalities of gait and mobility, and generalized muscle weakness. She received SN services. Her record, including the POC for certification period 12/29/17 to 2/26/18 was reviewed. During a home visit on 2/21/18 between 4:00 PM and 4:36 PM, an LPN was observed to provide wound care to Patient #3. The LPN was observed to wash her hands, don gloves, remove the old dressing, remove her gloves, don new gloves and finish the dressing change. She did not wash her hands between glove changes. During an interview on 2/23/18 at 11:00 AM, the LPN confirmed she did not wash her hands between glove changes. Handwashing did not occur in accordance with agency policy during a dressing change for Patient #3.	G 182	Please see the attached Plan of Correction	3.14.18
{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	{G 224}	Please see the attached Plan of Correction	3.14.18

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{G 224}	Continued From page 12 health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure written aide instructions were complete for 1 of 1 patient (Patient #1) whose care was observed provided by an aide and whose record was reviewed. This had the potential to interfere with safety and or coordination of patient care. Findings include: Patient #1 was a 68 year old female, admitted to the agency on 1/19/18, with a primary diagnosis of a fracture in the cervical region. Additional diagnoses included right rib fractures and abnormality of gait. She received, SN, PT, and aide services. Her record, including the POCs for the certification period 1/19/18 to 3/19/18, was reviewed. a. Patient #1's POC, dated 1/19/18, indicated she used a "cervical collar." A "Interdisciplinary Conference Report" note, dated 1/19/18, stated "Dr [name] says she does not need cervical collar except for riding in auto or increased activity with possibility of fall." A PT communication note, dated 1/23/18, signed by a Physical Therapist, stated "she is wearing a hard cervical collar, but is allowed out of it for short periods of time." Patient #1's aide care plan, initiated on 1/19/18, and printed as current on 2/20/18, did not address the cervical collar. For example, it did not guide the aide as to whether the cervical collar could be removed if Patient #1 was wearing it upon arrival of the aide to her home to give her a bath.	{G 224}	Please see the attached Plan of Correction	3.14.18

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{G 224}	Continued From page 13 b. During a home visit on 2/21/18 at 11:00 AM, Patient #1 was observed to be wearing a Life Alert device around her neck. Patient #1's aide care plan did not state whether Patient #1's Life Alert could or should be removed during her shower. During an interview on 2/22/18 at 1:30 PM, the Compliance Director confirmed the aide care plan did not address the cervical collar or Life Alert device. She stated it would be assumed the cervical collar was not necessary if it was not included on the care plan. Patient #1's aide care plan was incomplete.	{G 224}	Please see the attached Plan of Correction	3.14.18
{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. This STANDARD is not met as evidenced by: Based on record review, observation, policy review, and staff interview, it was determined the agency failed to ensure a medication list was kept current and reconciled for 1 of 4 patients (Patient #1) who were observed in the home. It also failed to notify the physician of a medication discrepancy for 1 of 8 patients (Patient #5) whose records were reviewed. These failures had the potential to compromise patient safety. Findings include:	{G 337}	Please see the attached Plan of Correction	3.14.18

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{G 337}	Continued From page 14 1. Agency policy N-24, "MEDICATION MANAGEMENT," revised 12/30/17, stated: - At the time of admit, the comprehensive assessment shall include a review of all current medications, including over-the-counter medications and Nutrition supplements." - "The physician is notified regarding any medication discrepancies, side effects, problems or reactions." - "Medication lists are to be updated for each change to reflect current medications, new and/or discontinued medications." The policy did not address how medication discrepancies would be reconciled once the physician was notified. The policy did not address nursing staff process for assessing for changes or updates to medication. For example, the policies did not address whether nursing staff was expected to review each medication or lay eyes on medication containers each visit or at specified intervals or whether it was sufficient to ask patients if there had been any changes. 2. A medication list was not kept current and reconciled. An example includes: Patient #1 was a 68 year old female admitted to the agency on 1/19/18, with a primary diagnosis of a fracture in the cervical region. Additional diagnoses included right rib fractures and abnormality of gait. She received, SN, PT, and aide services. Her record, including the POCs,	{G 337}	Please see the attached Plan of Correction	3.14.18

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{G 337}	Continued From page 15 for the certification period 1/19/18 to 3/19/18 was reviewed. During a home visit on 2/21/18 from 11:00 AM to 11:50 AM, Patient #1's medications were compared against the POC, dated 1/19/18 and subsequent orders since the initiation of the POC. The following discrepancies were found: - The POC included "acetaminophen 325 milligrams 2 by mouth every 4 hours, PRN for mild pain. Patient #1 stated she used ibuprofen rather than "Tylenol." - Patient #1 stated she had been taking a multivitamin with calcium and vitamin D "for about a month." The vitamin was not included on the POC. - The POC included an order for "oxybutynin 5 mg/24h." Patient #1 stated she took oxybutynin 5 mg 3 times per day rather than once a day. - The POC included multiple PRN medications for bowels, including Docusate, Dulcolax suppository, fleet enema, magnesium hydroxide, and milk of magnesia. Patient #1 stated she did not use any of those medications. During an interview on 2/22/18 at 1:30 PM, the Compliance Director confirmed the multivitamin and ibuprofen were missing from the POC. During a second interview on 2/23/18, the Compliance Director stated staff was aware of the discrepancies with the dosage of oxybutynin 5 mg and the bowel medications. She stated Patient #1 did not fill the prescriptions for the bowel medications. She provided a copy of a fax,	{G 337}	Please see the attached Plan of Correction	3.14.18

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{G 337}	Continued From page 16 dated 1/25/18, which notified the physician of the medication discrepancies. The physician faxed back a signed acknowledgment on 1/30/18. No clarification was obtained from the physician as to which dosage of oxybuynin Patient #1 should be taking and whether the bowel medications could/should be removed from the POC or whether Patient #1 should be encouraged to fill one or more of the prescriptions. Patient #1's current medication list did not reflect the medications and dosages of medications she was taking. 3. Patient #5 was a 38 year old female, who was admitted on 1/26/18, for care following total knee replacement. She was currently a patient as of 2/23/18. Patient #5's POC, for the certification period 1/26/18 to 3/26/18, stated she was allergic to Norco (Hydrocodone and Acetaminophen) and Morphine. The POC also stated Patient #5 had orders for Morphine and Lortab, which also contained Hydrocodone and Acetaminophen. An RN finalized Patient #5's POC on 2/07/18. An RN completed a "MEDICATION DISCREPANCY TOOL" on 1/29/18. The tool noted precautions with both the Morphine and the Hydrocodone. The tool did not identify Patient #5's allergy to Morphine and Hydrocodone. An RN completed a medication interaction form on 2/02/18. The form stated Morphine and Hydrocodone interacted with other medications. It did not state Patient #5 was allergic to Morphine and Hydrocodone. No documentation was present that the nurse identified Patient #5 was taking medication she was allegedly allergic to.	{G 337}	Please see the attached Plan of Correction	3.14.18

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{G 337}	Continued From page 17 The Compliance Director was interviewed on 2/23/18 beginning at 10:20 AM. She reviewed Patient #5's record and concurred the RN did not revise the POC to address the allergy. The agency did not review Patient #5's medications and identify prescribed medications she may have been allergic to.	{G 337}	Please see the attached Plan of Correction	3.14.18

G 144 COORDINATION OF PATIENT SERVICES

PLAN:

3/8/2018

A meeting of the management met to determine a plan to address written Notice of Deficiencies in relationship to recent follow up survey. It was determined to do a "Compliance Investigation" for each item identified in the notice to determine if the agencies processes or policies need to be revised in relationship to investigatory findings.

A new policy is to be developed that is specific to "Care Coordination" rather than the task being a part of the "Charting and Clinical Record" policy.

Follow up as appropriate will occur in relationship to the "Compliance Investigation" findings.

POLICY DEVELOPMENT

03/11/2018

The development of the following policy was completed to assure compliance to all federal and state requirements.

O-05.5 Coordination of Care

Education will be provided to staff in relationship to the policy changes on 3/14/2018. All policies are available for staff review to assure they are appropriately followed. The requirement to adhere to all company policies will be reinforced with all staff on an ongoing basis.

(See Attachment O-05.5)

IMPLEMENTATION OF PLAN:

Compliance Investigation:
A "Compliance Investigation" form was utilized for each of the 2 identified issues on the Notice of deficiencies. (See CI 1, CI 2). It was found that coordination with the supervising case manager was documented in each of the visit notes.

Compliance Investigation Resolution
Discussed the care coordination documentation with each staff member involved and will provide additional care coordination education with all staff on 3/14/2018. Will advise to staff to be specific with care coordination documentation and limit the location of documentation to the "Visit Contact" question of the visit note, the narrative of the visit note, or within a communication note.

FOLLOW UP: Follow up will continue as previously determined.

- Compliance to this requirement will be monitored by the Agency Branch Director with designated tasks to the ADON with the Episode audits (see attachments QA-2,3,4) . The ADON will complete the Episode Audits throughout each quarter as part of the documentation review process of the episodes.

  Performance Improvement Plan (PIP): each quarter the number of each Episode Audit type will equal to 10% of the average daily census will be entered in a Quality Tracking Sheet to determine the number of charts that contained appropriately documented and coordinated missed visits. The PIP will be evaluated as resolved when >90% of the reviews were in compliance for 2 consecutive quarters. This information will be included and tracked as part of the Quarterly QAPI reports.

  The QAPI Director will also complete a Quality Trend Analysis on 3 of the Clinical Chart Audits to assure that the evaluator is evaluating the requirements appropriately. The expectation will be that 100% of the Quality Trend Analysis reviews will show that the reviewer correctly evaluated the performance measure. This information will be included as part of the Quarterly QAPI reports.

  If during the course of the Episode Audits a trend is identified or an unresolvable issue related to non-compliance is identified, the ADON will complete a Compliance Investigation form (See attachment QA5). This form will be forwarded to the DON for appropriate investigation and interventions. The Compliance Investigation forms will be forwarded to the Administrator upon completion for review and incorporation into the quarterly Quality tracking.

  All Compliance Investigation Forms will be incorporated into the Quarterly QAPI report to show specific improvement efforts, areas for possible education needs, and guidance for adjustment to processes to assure ongoing compliance.

- Compliance to this requirement will be monitored by the Agency Branch Director, or designee, with the Quarterly Clinical Chart Audits (see attached QA-6) . The Branch Director will complete Clinical Chart Audits throughout each quarter in response to new employees, annual evaluations for employees, employees with documentation of concern or reported trends.

  Performance Improvement Plan (PIP): each quarter the number of Clinical Chart Audits equal to 10% of the average daily census will be entered in a Quality Tracking Sheet to determine the number of charts that contained the appropriate care coordination. The PIP will be evaluated as resolved when >90% of the reviews were in compliance for 2 consecutive quarters. This information will be included and tracked as part of the Quarterly QAPI reports.

  The QAPI Director will also complete a Quality Trend Analysis on 3 of the Clinical Chart Audits to assure that the evaluator is evaluating the requirements appropriately. The expectation will be that 100% of the Quality Trend Analysis reviews will show that the reviewer correctly evaluated the performance/compliance issues. This information will be included as part of the Quarterly QAPI reports.

Allegation of Compliance Date: 03/14/2018

G 159 PLAN OF CARE

PLAN:

3/8/2018

A meeting of the management met to determine a plan to address written Notice of Deficiencies in relationship to recent follow up survey. It was determined to do a "Compliance Investigation" for each item identified in the notice to determine if the agencies processes or policies need to be revised in relationship to investigatory findings.

A review of current policies associated with the findings were found to appropriately reflect and addresses the federal and state regulations. There is no plan to revise and policies at this time in relationship to this finding.

IMPLEMENTATION OF PLAN:

Compliance Investigation:

A "Compliance Investigation" form was utilized for each of the 4 identified issues on the Notice of deficiencies. (See CI 3, CI 4, CI 5, CI 6). It was found

- Life Alert was not included on the POC.
- A co-morbid diagnosis was inadvertently not coded on the POC.
- Incontinence supplies were inadvertently not added to the POC.
- Blood Sugar reporting parameters were not included on the POC.

Interviews with the staff and additional documentation review identified that the staff historically had never considered including the life alerts on the POC, therefore not including it.

An interview with the coder resulted in the coder already having an understanding of the need for all pertinent diagnosis to be included in the POC. It was an inadvertent oversight.

The nurse was interviewed related to not including the incontinent supplies on the POC. She did not realize that when adding supplies in the incontinent section that it didn't "auto-fill" to the POC like it does with DME/Supplies. The reviewing nurse had been confirming that all DME/Supplies in the DME/Supplies section and narrative section of the OASIS was appropriately reflected on the POC. She had never noticed the listing of supplies in the incontinence assessment of the OASIS.

A patient with diabetes (not the primary reason for admission) did not have blood sugar parameters included on the Plan of Care. This plan of care was developed prior to the "Plan of Care" training provided and prior to the day of alleged compliance. An interview with the nurse to inquire as to why the care plan was not updated revealed that she did not understand it needed to be as she felt the parameters could revert to the agency defined reporting parameters if no specific parameters were defined on the plan of care.

Compliance Investigation Resolution

Education will be provided to all staff on 3/14/2018 to assure that all equipment (including Life Alert) is included in the plan of care.

The coder and the OASIS review will verify with each review that all pertinent diagnosis are included in the diagnosis, and if appropriate include goals and interventions as verified with education provided on 2/22/2018.

The nursing staff along with the OASIS reviewer will be educated on 3/14/2018 to assure that all equipment/supplies being utilized are entered in the DME/Supplies section of the OASIS. The OASIS reviewer will assure that all supplies listed merged to the POC appropriately.

The nursing staff will be educated/reminded on 3/14/2018 that if the patient does not have specific reporting parameters, the reporting requirements revert back to policy "O-013.5 Physician Reporting Guidelines" and the agency specific reporting guidelines. Follow up with the physician needs to occur if patient findings are outside of the patient specific or agency identified reporting requirements.

FOLLOW UP: Follow up will continue as previously determined.

Compliance to this requirement will be monitored by the Agency Branch Director with designated tasks to the ADON with the Episode audits (see attachments QA-2,3,4) . The ADON will complete the Episode Audits throughout each quarter as part of the documentation review process of the episodes.

Performance Improvement Plan (PIP): each quarter the number of each Episode Audit type will equal to 10% of the average daily census will be entered in a Quality Tracking Sheet to determine the number of charts that contained POC's that covered all pertinent diagnoses, equipment and supplies. The PIP will be evaluated as resolved when >90% of the reviews were in compliance for 2 consecutive quarters. This information will be included and tracked as part of the Quarterly QAPI reports.

If during the course of the Episode Audits a trend is identified or an unresolvable issue related to non-compliance is identified, the ADON will complete a Compliance Investigation form (See attachment QA5). This form will be forwarded to the DON for appropriate investigation and interventions. The Compliance Investigation forms will be forwarded to the Administrator upon completion for review and incorporation into the quarterly Quality tracking.

All Compliance Investigation Forms will be incorporated into the Quarterly QAPI report to show specific improvement efforts, areas for possible education needs, and guidance for adjustment to processes to assure ongoing compliance.

The QAPI Director will also complete a Quality Trend Analysis on 3 of the Clinical Chart Audits to assure that the evaluator is evaluating the requirements appropriately. The expectation will be that 100% of the Quality Trend Analysis reviews will show that the reviewer correctly evaluated the performance measure. This information will be included as part of the Quarterly QAPI reports.

Allegation of Compliance Date: 03/14/2018

G 170 SKILLED NURSING SERVICES

PLAN:

3/8/2018

A meeting of the management met to determine a plan to address written Notice of Deficiencies in relationship to recent follow up survey. It was determined to do a "Compliance Investigation" for each item identified in the notice to determine if the agencies processes or policies need to be revised in relationship to investigatory findings.

A review of current policies associated with the findings were found to appropriately reflect and addresses the federal and state regulations. There is no plan to revise and policies at this time in relationship to this finding.

IMPLEMENTATION OF PLAN:

Compliance Investigation:

A "Compliance Investigation" form was utilized for each of the 1 identified issues on the Notice of deficiencies. (See CI 7). It was found:

- The POC included an intervention to "Assess weight change", no weights were obtained after the initial visit.

Interviews with the initial assessing nurse and the nurse that assumed the case management role identified the following.

- A different nurse other than the nurse who assumed case manager responsibilities did the initial evaluation.
- The patient was admitted for care related to a neck surgery, CHF was not the primary reason for admission
- The initial assessing nurse documented a reported weight from the hospital on the OASIS.
- The case manager did not notice the interventions for weight management in her first few visits, she was focusing on the neck surgery issues, ADL's with recent surgery, and pain management. When she noticed the weight management intervention is was determined the patient did not have a scale, and did not have a way of obtaining one.
- The case manager provided the patient with a scale to begin monitoring the patient.

Compliance Investigation Resolution

Clinical Manager discussed the policies in relationship to the management of CHF patients and assuring that the Plan of Care is being followed as ordered with the Case Manager. The Case Manager verbalized understanding of the requirement and assures a closer review of all interventions upon providing cares. Clinical Manager is going to work with the staff to determine a way that could better facilitate a "hand off" procedure when a nurse, other than the RN that will continue with the case manager responsibilities, does the initial evaluation and plan of care development.

FOLLOW UP: Follow up will continue as previously determined.

Compliance to this requirement will be monitored by the Agency Branch Director, or designee, with the Quarterly Clinical Chart Audits Clinical Chart Audit (see attached QA-6) . The Branch Director will complete Clinical Chart Audits throughout each quarter in response to new employees, annual evaluations for employees, employees with documentation of concern or reported trends by staff.

Performance Improvement Plan (PIP): each quarter the number of Clinical Chart Audits equal to 10% of the average daily census will be entered in a Quality Tracking Sheet to determine the number of charts that contained that the POC and subsequent orders were appropriately followed. Each item will be evaluated as resolved when >90% of the reviews were in compliance for 2 consecutive quarters. This information will be included and tracked as part of the Quarterly QAPI reports.

The QAPI Director will also complete a Quality Trend Analysis on 3 of the Clinical Chart Audits to assure that the evaluator is evaluating the requirements according to requirements. The expectation will be that 100% of the Quality Trend Analysis reviews will show that the reviewer correctly evaluated the performance measure. This information will be included as part of the Quarterly QAPI reports.

Allegation of Compliance Date: 03/14/2018

G 170 SKILLED NURSING SERVICES

PLAN:

3/8/2018

A meeting of the management met to determine a plan to address written Notice of Deficiencies in relationship to recent follow up survey. It was determined to do a "Compliance Investigation" for each item identified in the notice to determine if the agencies processes or policies need to be revised in relationship to investigatory findings.

A review of current policies associated with the findings were found to appropriately reflect and addresses the federal and state regulations. There is no plan to revise and policies at this time in relationship to this finding.

IMPLEMENTATION OF PLAN:

Compliance Investigation:

A "Compliance Investigation" form was utilized for each of the 2 identified issues on the Notice of deficiencies. (See CI 7). It was found:

- The POC included an intervention to "Assess weight change", no weights were obtained after the initial visit.

Interviews with the initial assessing nurse and the nurse that assumed the case management role identified the following.

- A different nurse other than the nurse who assumed case manager responsibilities did the initial evaluation.
- The patient was admitted for care related to a neck surgery, CHF was not the primary reason for admission
- The initial assessing nurse documented a reported weight from the hospital on the OASIS.
- The case manager did not notice the interventions for weight management in her first few visits, she was focusing on the neck surgery issues, ADL's with recent surgery, and pain management. When she noticed the weight management intervention is was determined the patient did not have a scale, and did not have a way of obtaining one.
- The case manager provided the patient with a scale to begin monitoring the patient.

Compliance Investigation Resolution

Clinical Manager discussed the policies in relationship to the management of CHF patients and assuring that the Plan of Care is being followed as ordered with the Case Manager. The Case Manager verbalized understanding of the requirement and assures a closer review of all interventions upon providing cares. Clinical Manager is going to work with the staff to determine a way that could better facilitate a "hand off" procedure when a nurse, other than the RN that will continue with the case manager responsibilities, does the initial evaluation and plan of care development.

The Clinical Manager will provide education to the staff in relationship to appropriate "hand off" coordination when a different clinician, other than the case manager completes the comprehensive assessment to develop the plan of care. Prior to the plan of care being submitted to the physician for approval, the case manager will receive a copy of the plan of care for review and approval. Upon approval of the plan of care it is the case managers responsibility that any visits performed are in compliance with the plan of care and is appropriately documented in the clinical record. Documentation of the coordination with the case manager will be documented in the patient's clinical record in a communication note.

FOLLOW UP: Follow up:

The Start of Care, Resumption, Recertification and Clinical audits were revised and reviewed to include the following items:

485 Treatments, procedures, parameters, labs, etc. reflect the ordered services and the patient's level of care. The services are appropriate to the abilities and resources of the patient.

Visits follow the plan of care goals, interventions and reporting parameters or subsequent orders (i.e. wound care, BG', etc)

Compliance to this requirement will be monitored by the Agency Branch Director, or designee, with the Quarterly Clinical Chart Audits Clinical Chart Audit (see attached QA-6) . The Branch Director will complete Clinical Chart Audits throughout each quarter in response to new employees, annual evaluations for employees, employees with documentation of concern or reported trends by staff.

A Compliance Investigation will be completed for any non-compliant item identified with the review with appropriate intervention and follow up to address the identified issue/s.

All Compliance Investigations will be incorporated as part of the Quarterly QAPI review. Any trends identified will be followed up appropriately in accordance to the issue and follow up needed.

Performance Improvement Plan (PIP): each quarter the number of Clinical Chart Audits equal to 10% of the average daily census will be entered in a Quality Tracking Sheet to determine the number of charts that contained that the POC and subsequent orders were appropriately followed. Each item will be evaluated as resolved when >90% of the reviews were in compliance for 2 consecutive quarters. This information will be included and tracked as part of the Quarterly QAPI reports.

The QAPI Director will also complete a Quality Trend Analysis on 3 of the Clinical Chart Audits to assure that the evaluator is evaluating the requirements according to requirements. The expectation will be that 100% of the Quality Trend Analysis reviews will show that the reviewer correctly evaluated the performance measure. This information will be included as part of the Quarterly QAPI reports.

Allegation of Compliance Date: 03/14/2018

G 173 DUTIES OF THE REGISTERED NURSE

PLAN:

3/8/2018

A meeting of the management met to determine a plan to address written Notice of Deficiencies in relationship to recent follow up survey. It was determined to do a "Compliance Investigation" for each item identified in the notice to determine if the agencies processes or policies need to be revised in relationship to investigatory findings.

A review of current policies associated with the findings were found to appropriately reflect and addresses the federal and state regulations. There is no plan to revise and policies at this time in relationship to this finding.

IMPLEMENTATION OF PLAN:

Compliance Investigation:

A "Compliance Investigation" form was utilized for each of the 1identified issues on the Notice of deficiencies. (See CI 8). It was found:

- It was confirmed that the medication list was not updated at the time the RN identified the ordered antibiotic.

An interview with the RN identified that she didn't think she could update the medication list until she had it confirmed from the physician due to the original orders being provided by a PA. She notified the physician in writing as the physician will not provide verbal orders. The PA works with the patient's physician in the same office. The nurse felt like she made decisions that were for the benefit for the patient.

Compliance Investigation Resolution

The nurse was instructed to assure that all steps to verify the medication prior to adding the medication to the medication list is clearly documented and recommended inclusion of the information that the PA and the physician work in the same office together and the PA saw the patient in the "Urgent Care" and did not have control as to who provided the medical intervention when she sought treatment.
It was reinforced to the nurse the necessity to have physician orders prior to updating the medication list, the necessity for timely follow up with the physician with any medication discrepancies/changes and the clear documentation of all steps made.

FOLLOW UP: Follow up will continue as previously determined.

- Compliance to this requirement will be monitored by the Agency Branch Director with designated tasks to the ADON with the Episode audits (see attachments QA-2,3,4) . The ADON will complete the Episode Audits throughout each quarter as part of the documentation review process of the episodes.

Performance Improvement Plan (PIP): each quarter the number of each Episode Audit type will equal to 10% of the average daily census will be entered in a Quality Tracking Sheet to determine the number of charts that contained POC's with goals and interventions that appropriately met the patients needs. The PIP will be evaluated as resolved when >90% of the reviews were in compliance for 2 consecutive quarters. This information will be included and tracked as part of the Quarterly QAPI reports

If during the course of the Episode Audits a trend is identified or an unresolvable issue related to non-compliance is identified, the ADON will complete a Compliance Investigation form (See attachment QA5). This form will be forwarded to the DON for appropriate investigation and interventions. The Compliance Investigation forms will be forwarded to the Administrator upon completion for review and incorporation into the quarterly Quality tracking.

All Compliance Investigation Forms will be incorporated into the Quarterly QAPI report to show specific improvement efforts, areas for possible education needs, and guidance for adjustment to processes to assure ongoing compliance.

The QAPI Director will also complete a Quality Trend Analysis on 3 of the Clinical Chart Audits to assure that the evaluator is evaluating the requirements appropriately. The expectation will be that 100% of the Quality Trend Analysis reviews will show that the reviewer correctly evaluated the performance measure. This information will be included as part of the Quarterly QAPI reports.

- Compliance to this requirement will be monitored by the Agency Branch Director, or designee, with the Quarterly Clinical Chart Audits Clinical Chart Audit (see attached QA-6) . The Branch Director will complete Clinical Chart Audits throughout each quarter in response to new employees, annual evaluations for employees, employees with documentation of concern or reported trends by staff.

  Performance Improvement Plan (PIP): each quarter the number of Clinical Chart Audits equal to 10% of the average daily census will be entered in a Quality Tracking Sheet to determine the number of charts that contained that the POC is appropriately adjusted to meet the needs of the patient. Each item will be evaluated as resolved when >90% of the reviews were in compliance for 2 consecutive quarters. This information will be included and tracked as part of the Quarterly QAPI reports.

  The QAPI Director will also complete a Quality Trend Analysis on 3 of the Clinical Chart Audits to assure that the evaluator is evaluating the requirements appropriately. The expectation will be that 100% of the Quality Trend Analysis reviews will show that the reviewer correctly evaluated the performance measure. This information will be included as part of the Quarterly QAPI reports.

Allegation of Compliance Date: 03/14/2018

G 182 DUTIES OF THE LICENSED PRACTICAL NURSE

PLAN:

3/8/2018

A meeting of the management met to determine a plan to address written Notice of Deficiencies in relationship to recent follow up survey. It was determined to do a "Compliance Investigation" for each item identified in the notice to determine if the agencies processes or policies need to be revised in relationship to investigatory findings.

A review of current policies associated with the findings were found to appropriately reflect and addresses the federal and state regulations. There is no plan to revise and policies at this time in relationship to this finding.

IMPLEMENTATION OF PLAN:

Compliance Investigation:

A "Compliance Investigation" form was utilized for each of the 1 identified issues on the Notice of deficiencies. (See CI 9). It was found

- The LPN did not wash hands between glove changes.

An interview with the LPN identified that the LPN is aware that she needs wash her hands or use anti-bacterial gel in between glove changes. She stated she was nervous due to a variety of things that occurred prior to and during the visit in conjunction with being watched during her visit.

Compliance Investigation Resolution

Education was provided to the LPN regarding the requirement to wash her hands/use sanitizing gel in between glove changes. She stated she was aware, and next time she won't worry about "who's watching" she will just take care of the patient.

A handwashing in-service will be provided to all staff on 3/14/2018.

FOLLOW UP: Follow up will continue as previously determined.

Compliance to this requirement will be monitored by the Agency Branch Director with all onsite annual evaluation visits with the staff. She will assure that proper handwashing techniques will be observed.

An annual training in relationship to infection control will occur, including proper handwashing techniques.

Documentation of all onsite visits and infection control education will be maintained by the Agency Branch Director.

Allegation of Compliance Date: 03/14/2018

G 224 ASSIGNMENT & DUTIES OF HOME HEALTH

PLAN:

3/8/2018

A meeting of the management met to determine a plan to address written Notice of Deficiencies in relationship to recent follow up survey. It was determined to do a "Compliance Investigation" for each item identified in the notice to determine if the agencies processes or policies need to be revised in relationship to investigatory findings.

A review of current policies associated with the findings were found to appropriately reflect and addresses the federal and state regulations. There is no plan to revise and policies at this time in relationship to this finding.

IMPLEMENTATION OF PLAN:
Compliance Investigation:
A "Compliance Investigation" form was utilized for each of the 1 identified issues on the Notice of deficiencies. (See CI 10). It was found:

- The aide care plan did not include to not use the patients c-collar or the life alert in the shower.

An interview with the RN that developed the plan of care stated that it did not occur to include things on the care plan that would not be used, she only included equipment that should be used. She stated that if the aide was not sure if it should be used or not, a call should have been placed to a qualified registered nurse for additional guidance, along with any other equipment or supply that he/she were unsure of.

Compliance Investigation Resolution
Education will be provided to all staff on 3/14/2018, that if there is equipment that could be essential to the care of the patient, specific guidance should be included in the Home Health Aide plan of care.

FOLLOW UP: Follow up will continue as previously determined.

Compliance to this requirement will be monitored by the Agency Administrator, or designee, with monthly employee file reviews. The Administrator will complete monthly employee file reviews throughout each quarter in response to new employees and annual evaluations for employees.

Performance Improvement Plan (PIP): each quarter the monthly employee file reviews will be entered in a Quality Tracking Sheet to determine the number of files that contained the HHA initial competency evaluation and an appropriately completed annual evaluation. The PIP will be evaluated as resolved when >90% of the reviews were in compliance for 2 consecutive quarters. This information will be included and tracked as part of the Quarterly QAPI reports.

Compliance to this requirement will be monitored by the Agency Branch Director, or designee, with the Quarterly Clinical Chart Audits Clinical Chart Audit (see attached QA-6) . The Branch Director will complete Clinical Chart Audits throughout each quarter in response to new employees, annual evaluations for employees, employees with documentation of concern or reported trends by staff.

Performance Improvement Plan (PIP): each quarter the number of Clinical Chart Audits equal to 10% of the average daily census will be entered in a Quality Tracking Sheet to determine the number of charts that contained a written HHA POC that appropriately reflects the care to be provided by the HHA and appropriate aide supervision. Each item will be evaluated as resolved when >90% of the reviews were in compliance for 2 consecutive quarters. This information will be included and tracked as part of the Quarterly QAPI reports.

The QAPI Director will also complete a Quality Trend Analysis on 3 of the Clinical Chart Audits to assure that the evaluator is evaluating the requirements according to requirements. The expectation will be that 100% of the Quality Trend Analysis reviews will show that the reviewer correctly evaluated the performance measure. This information will be included as part of the Quarterly QAPI reports.

Allegation of Compliance Date: 03/14/2018

G 337 DRUG REGIMEN REVIEW

PLAN:

3/8/2018

A meeting of the management met to determine a plan to address written Notice of Deficiencies in relationship to recent follow up survey. It was determined to do a "Compliance Investigation" for each item identified in the notice to determine if the agencies processes or policies need to be revised in relationship to investigatory findings.

A revised policy is to be developed that is specific to "Medication Management" clarifying how medication discrepancies would be reconciled once the physician was notified and the nursing staff process for assessing for changes or updates to medication.

POLICY DEVELOPMENT

03/11/2018

The development of the following policy was completed to assure compliance to all federal and state requirements.

N-24 Medication Management

Education will be provided to staff in relationship to the policy changes on 3/14/2018. All policies are available for staff review to assure they are appropriately followed. The requirement to adhere to all company policies will be reinforced with all staff on an ongoing basis.

(See Attachment N-24)

IMPLEMENTATION OF PLAN:

Compliance Investigation:

A "Compliance Investigation" form was utilized for each of the 2 identified issues on the Notice of deficiencies. (See CI 11, CI 12). It was found:

- The Medication Management policy would benefit with a revision to clarify the Agency's expectation for compliance.
- Inaccurate medication list

Interviews with the staff and additional chart review identified:

- Initial medication reconciliation was difficult due to a family member outside of the home managed the patient's medications and kept the medications at their home. They refused the nurse to come out and visually check the medications.
- The nurse entered the medication list into the Agency's EDR in accordance with the written order received from the hospital.

- With information the nurse could obtain from the patient there appeared to be a dosage and frequency issue with some of the medications. After failure to receive a verbal order, the nurse sent a Medication Discrepancy Tool form to the physician to request clarification to the dosage and frequency. Upon receipt of the signed order from the physician, the physician only signed the order, and did not clarify the frequency. The nurse attempted to call the office for clarification and did not get a response. The order was re-faxed to the physician with a request to clarify the dosage and frequency.
- There was no documentation in the chart in relationship to attempts to contact the physician. There was no documentation in the chart in relationship to re-sending the order for clarification.
- The patient was asked at each visit if there had been any changes to her medications. The patient denied. However, the nurse did not ask her about each individual medication to clarify.

Compliance Investigation Resolution

The staff has been educated repeatedly on medication management and are doing due diligence to comply. Unique situations in which the basic reconciliation process can be utilized is the area requiring additional follow up.

The Director of Nursing is going to inform the staff on 3/14/2018 to coordinate with her and the QAPI/Compliance director if non-traditional situations occur that interferes with the normal process for medication reconciliation. Each issue will be addressed on a case by case basis to assure compliance.

FOLLOW UP: Follow up will continue as previously determined.

Compliance to this requirement will be monitored by the Agency Branch Director, or designee, with the Quarterly Clinical Chart Audits Clinical Chart Audit (see attached QA-6) . The Branch Director will complete Clinical Chart Audits throughout each quarter in response to new employees, annual evaluations for employees, employees with documentation of concern or reported trends by staff.

Performance Improvement Plan (PIP): each quarter the number of Clinical Chart Audits equal to 10% of the average daily census will be entered in a Quality Tracking Sheet to determine the number of charts that contained that the OASIS comprehensive assessment was complete, consistent and appropriately represented the patient's status. Each item will be evaluated as resolved when >90% of the reviews were in compliance for 2 consecutive quarters. This information will be included and tracked as part of the Quarterly QAPI reports.

Compliance to this requirement will be monitored by the Agency Branch Director with designated tasks to the ADON with the Episode audits (see attachments QA-2,3,4) . The ADON will complete the Episode Audits throughout each quarter as part of the documentation review process of the episodes.

Performance Improvement Plan (PIP): each quarter the number of each Episode Audit type will equal to 10% of the average daily census will be entered in a Quality Tracking Sheet to determine the number of charts that contained appropriately managed medication lists. The PIP will be evaluated as resolved when >90% of the reviews were in compliance for 2 consecutive quarters. This information will be included and tracked as part of the Quarterly QAPI reports.

If during the course of the Episode Audits a trend is identified or an unresolvable issue related to non-compliance is identified, the ADON will complete a Compliance Investigation form (See attachment QA5). This form will be forwarded to the DON for appropriate investigation and interventions. The Compliance Investigation forms will be forwarded to the Administrator upon completion for review and incorporation into the quarterly Quality tracking.

All Compliance Investigation Forms will be incorporated into the Quarterly QAPI report to show specific improvement efforts, areas for possible education needs, and guidance for adjustment to processes to assure ongoing compliance.

The QAPI Director will also complete a Quality Trend Analysis on 3 of the Clinical Chart Audits to assure that the evaluator is evaluating the requirements appropriately. The expectation will be that 100% of the Quality Trend Analysis reviews will show that the reviewer correctly evaluated the performance measure. This information will be included as part of the Quarterly QAPI reports.

Allegation of Compliance Date: 03/14/2018