IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
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April 27, 2018

Barbara Kirkpatrick, Administrator
North Idaho Home Health
850 W Kathleen Avenue
Coeur d Alene, ID 83815

RE: North Idaho Home Health, Provider #137019

Dear Ms. Kirkpatrick:

This is to advise you of the findings of the Medicare/Licensure survey, which was concluded at your facility on April 19, 2018.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare 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 into compliance, and that the home health 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.

After you have completed your Plan of Correction, return the original to this office by **May 7, 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, 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
	137019	A. BUILDING _____ B. WING _____	04/19/2018

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NORTH IDAHO HOME HEALTH	850 W KATHLEEN AVENUE COEUR DALENE, ID 83815

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G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your agency conducted on 4/16/18 to 4/19/18. Surveyors conducting the Medicare recertification survey were: James Brown, RN, HFS, Team Lead Nancy Bax, RN, BSN, HFS Teresa Hamblin, RN, MS, HFS Acronyms used in this report include: ALF - Assisted Living Facility ASHD - Atherosclerotic Heart Disease BP - Blood Pressure CHF - Congestive Heart Failure COPD - Chronic Obstructive Pulmonary Disease DON - Director of Nursing DM - Diabetes Mellitus DME - Durable Medical Equipment ESRD - End Stage Renal Disease HCL - Hydrochloride HRS - Hours HTN - Hypertension IV - Intravenous LPN - Licensed Practical Nurse LUE - Left Upper Extremity MD/SBAR- Medical Doctor Situation, Background, Assessment, Recommendation (used to communicate patient assessment information electronically to the MD) MG/mg - Milligram MRSA - Methicillin-Resistant Staphylococcus Aureus MSW - Medical Social Worker PRN - as needed PT - Physical Therapy	G 000	RECEIVED MAY - 7 2018 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara Kirkpatrick RN | TITLE: Executive Director | (X6) DATE: 5-5-18

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 000	Continued From page 1 PTA- Physical Therapy Assistant POC - Plan of Care OASIS - Outcome and Assessment Information Set OT - Occupational Therapy RN - Registered Nurse SN - Skilled Nursing SOB - Shortness of Breath SOC - Start of Care ST - Speech Therapy UTI - Urinary Tract Infection	G 000		
G 374	Accuracy of encoded OASIS data CFR(s): 484.45(b) The encoded OASIS data must accurately reflect the patient's status at the time of assessment. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure encoded OASIS data reflected the patients' status at the time of assessment for 2 of 13 patients (#4 and #8) whose records were reviewed. This failure resulted in inaccuracies between the SOC assessment and OASIS data. Findings include: 1. Patient #4 was an 83 year old female admitted to the agency on 3/23/18, with a primary diagnosis of injury to the right lower leg. Additional diagnoses included HTN and history of falling. She received SN services. Her record, including the POC, for the certification period 3/23/18 to 5/21/18, was reviewed. Patient #4's record included an SOC comprehensive assessment, including OASIS items, dated 3/23/18, signed by the RN Case Manager. The OASIS did not accurately reflect	G 374	Executive Director reviewed Policy 7.013 OASIS accuracy with staff to include Clinicians and Patient Care Managers. The focus of the education was to outline the process/procedure to validate OASIS accuracy. Education to include review of proper response to M2001, M2003 and M1870 utilizing OASIS Tips Sheets. The field clinician will be responsible to complete a comprehensive assessment and review for accuracy prior to submission to Patient Care Manager/Executive Director: within 24 hours and Executive Recommended changes will be reviewed with OASIS assessing clinicians. Director/Patient Care Manager will review within 1 business day for accuracy. Beginning May 7th Executive Director/Patient Care Manger will complete audits of 3 OASIS assessment weekly to verify information on the OASIS assessment are accurate X 8weeks and until compliance 100% X 2 consecutive months.	5/10/18

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G 374	Continued From page 2 her current status. Examples include: a. Patient #4's record included an "MD/SBAR COMMUNICATION" dated 3/24/18, entered by the RN Case Manager. The note stated "SIGNIFICANT EVENT/PROBLEM: THERE ARE MEDICATION DISCREPANCIES FROM YOUR MEDICATION LIST TO WHAT THE PATIENT ACTUALLY HAS IN THE HOME." The note stated Patient #4 was not taking 4 medications that were on the physician's medication list, and she was taking 3 medications that were not on the physician's medication list. Patient #4's RN Case Manager identified discrepancies between her physician ordered medications and what she was taking in her home. Patient #4's SOC assessment included OASIS item M2001, "DID A COMPLETE DRUG REGIMEN REVIEW IDENTIFY POTENTIAL CLINICALLY SIGNIFICANT MEDICATION ISSUES?" It was answered "NO ISSUES FOUND DURING REVIEW." During an interview on 4/19/18 at 8:00 AM, the RN Case Manager confirmed issues were identified during the review of Patient #4's medications at SOC. She confirmed OASIS item M2001 was inaccurate. b. Patient #4's SOC assessment stated she lived with her daughter, who worked during the day. There was no documentation of assistance available during the daytime hours. OASIS item M1870 stated "UNABLE TO FEED SELF AND MUST BE ASSISTED OR SUPERVISED THROUGHOUT THE MEAL/SNACK." It was unclear who would provide assistance with feeding during the daytime hours when Patient	G 374	Executive Director is responsible for implementing the plan of correction	

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G 374	Continued From page 3 #4's daughter was at work. During an interview on 4/19/18 at 8:00 AM, the RN Case Manager reviewed Patient #4's SOC assessment and stated OASIS item M1870 was answered inaccurately. She stated Patient #4 was able to feed herself. Patient #4's SOC OASIS did not accurately reflect her status. 2. Patient #8 was an 81 year old female admitted to the agency on 10/18/17 with diagnoses of muscle weakness, HTN, COPD, major depressive disorder, and atrial fibrillation. She received SN, PT, and OT services. Her record, including the POC, for certification period 10/18/17 to 12/16/17, was reviewed. "Client Coordination Note Reports," dated 10/18/17, identified interactions with Patient #S's medications. The interactions were classified as severity level 3, a moderate interaction, and included a note to assess the risk to the patient and take action as needed: - Digoxin oral interacted with Diltiazem oral, Furosemide oraland Mi-acid oral. - Diltiazem oral interacted with Pradaxa oral. - Duloxetine oral interacted with pain reliever oral and Pradaxa oral. - Furosemide oral interacted with Sucralfate oral. - Olanzapine oral interacted with Ondanestron HCL oral The SOC assessment including the OASIS for Patient #8 was completed by the RN on 10/18/17. OASIS item M2003, indicated the agency contacted a physician (or physician-designee) by midnight of the next calendar day and completed	G 374		

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G 374	Continued From page 4 prescribed recommended actions in response to the identified potentially clinically significant medication issues. There was no documentation in Patient #S's record that these potential medication interactions had been communicated to the physician. There was no documented acknowledgement from the physician to continue or change the POC based on awareness of these medication interactions. During an interview on 4/18/18 at 2:25 PM, the DON confirmed there was no documentation in Patient #S's medical record that the potential medication interactions were communicated to the physician by midnight of the next calendar day. The encoded OASIS data for Patient #8 as it related to M2003 was not accurate.	G 374		
G 434	Participate in care CFR(s): 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of allassessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including	G 434	Executive Director provided education to all staff on Policy 1.001 Patient Rights and Responsibility. Executive Director reviewed expectations with clinicians to offer and provide all applicable patient services based on patient needs and to adhere to established visiting patterns and frequencies. During start of care conference, clinicians and patient care managers will review assessment findings and ensure applicable services have been implemented.	5/10/18

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G 434	Continued From page 5 patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. This ELEMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure patients/family members were given the opportunity to participate in their POCs related to services provided and frequency of visits for 1 of 13 patients (Patient #10) whose records were reviewed. This failure had the potential to result in unmet patient needs. Findings include: 1. Patient #10 was a 70 year old male admitted to the agency on 4/25/17, with a primary diagnosis of infection of a graft in his chest wall. Additional diagnoses included MRSA infection and adult failure to thrive. He received SN, PT, and OT services. Patient #10 was discharged from the agency on 5/01/17. His record, including the POC, for the certification period 4/25/17 to 6/23/17, was reviewed. a. Patient's #10's record included an SOC comprehensive assessment, dated 4/25/17, signed by the RN Case Manager. The assessment documented he depended entirely upon another person for grooming, dressing, bathing, and toileting hygiene. Patient #10's record did not include documentation Patient #10 or his family were informed of the availability of home health aide services to provide grooming, dressing, and bathing assistance. During an interview on 4/18/18 at 10:00 AM, the RN Case Manager reviewed Patient #10's SOC	G434	Beginning May 7, 2018, the Executive Director/designee will audit 5 patient records weekly X 8 weeks or until 100% compliance X two months to ensure that patient's rights were followed through prior to the initiation of care and while receiving services to include the initiation of all applicable services. Executive Director is responsible for implementing the plan of correction	

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G 434	Continued From page 6 assessment and confirmed he required maximum assistance for his personal care. She stated his payer required pre-authorization for aide services. The RN Case Manager confirmed there was no documentation of discussion with Patient #10 or his family regarding aide services or documentation of an attempt to obtain pre-authorization for aide services. The agency failed to ensure Patient #10 and his family were informed of the availability of aide services. b. Patient #1O's record included an "ON CALL" note, dated 4/29/17, signed by an LPN. The note stated Patient #1O's spouse called to report he was having increased weakness, confusion, and agitation, as well as diarrhea. The spouse expressed concerns about her ability to safely care for him. The note stated Patient #1O's spouse was informed an SN visit would be made the following day, 4/30/17. There was no documentation of an SN visit or communication with Patient #1O's spouse on 4/30/17. During an interview on 4/18/18 at 10:00 AM, the RN Case Manager confirmed Patient #1O's record did not include documentation of an SN visit on 4/30/17. She was unable to determine the reason an SN visit was not completed. The agency failed to ensure Patient #1O's spouse was informed of changes in the care to be furnished.	G434		
G 440	Payment from federally funded programs CFR(s): 484.50(c)(7)(i, ii, iii, iv) Be advised of --	G440		

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G 440	Continued From page 7 (i) The extent to which payment for HHA services may be expected from Medicare, Medicaid, or gny other federally-funded or federal aid program known to the HHA, (ii) The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA, (iii) The charges the individual may have to pay before care is initiated; and (iv) Any changes in the information provided in accordance with paragraph (c)(7) of this section when they occur. The HHA must advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit. The HHA must comply with the patient notice requirements at 42 CFR 411.408(d)(2) and 42 CFR 411.408(f). This ELEMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure patients were informed in writing of the extent to which payment could be expected and the charges the individual might have to pay for 1 of 2 patients (Patient #10) for whom a Medicare Advantage Plan was the payer and whose records were reviewed. This failure had the potential to interfere with patients'/caregivers' ability to make reasonable, informed decisions about financial matters related to the agency's care and treatment. Findings include: Patient #10 was a 70 year old male admitted to the agency on 4/25/17, with a primary diagnosis of infection of a graft in his chest wall. Additional diagnoses included MRSA infection and adult failure to thrive. He received SN, PT, and OT services. Patient #10 was discharged from the	G440	Executive Director reviewed with Staff on 5/03/18 Policy 01.015 Patient Financial Responsibility with focus of education that the patient will be informed of any potential financial liability for services in writing and the responsibility and the clinician to complete the payment section of the paper consent form located in the admission booklet. Beginning May 7, 2018, Executive Director/ designee will perform 4 home visits/month to recently admitted patients for 2 months or until 100% compliance achieved to assure proper patient notification of potential financial liability for home health services has been provided in writing to the patients. Executive Director responsible to implement the plan.	5/10/18

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G 440	Continued From page 8 agency on 5/01/17. His record, including the POC, for the certification period 4/25/17 to 6/23/17, was reviewed. Patient #1O's record included a consent form signed by the patient and the RN Case Manager on 4/25/17. The form stated "Payment for services received by the patient will be made from the following sources." The box next to "Medicare Advantage Plan" was checked. The form stated "Since I am Self-pay or have Group/Private or Medicare Advantage Plan, it has been determined that my financial liability for deductible, co-insurance, or co-pay per visit until I reach my Out of Pocket Maximum will be as follows." The form included lines to document amounts next to "Deductible," "Co-Insurance," "Co-pay per visit," and "Out of Pocket Maximum." The 4 lines were blank. The form did not include information to advise Patient #10 of possible financial liability for the home health services he received. During an interview on 4/18/18 at 10:00 AM, the DON reviewed Patient #1O's consent form and confirmed there was no documentation stating he was advised of potential out of pocket expenses for the home health services he received. The agency failed to ensure patients were informed of their potential financial liability for home health services, prior to the start of care.	G440		
G 514	RN performs assessment CFR(s): 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for	G 514		

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G 514	Continued From page 9 Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician- ordered start of care date. This ELEMENT is not met as evidenced by: Based on medical record review, agency policy review, and staff interview, it was determined the agency failed to ensure the initial patient assessment was performed within 48 hours of physician referral for 1 of 13 patients (Patient #9) whose records were reviewed. This failure had the potential to result in unmet patient needs. Findings include: The agency's policy "PATIENT ASSESSMENT, INITIALAND REASSESSMENT" revised 2/01/18, stated "A qualified clinician performs a comprehensive assessment or reassessment visit in the following situations: Admission visit within 48 hours from referral or physician ordered start of care date." Patient #9 was an 83 year old male admitted to the agency on 9/22/17, with a primary diagnosis of dizziness. Additional diagnoses included gastroparesis, depression, history of falling, and dependence on supplemental oxygen. He received SN, PT, OT, MSW, and aide services. His record, including the POC, for the certification period 9/22/17 to 11/20/17, was reviewed. Patient #9's record included a referral order for home health services, dated 9/19/17, signed by his physician. His record included an SOC comprehensive assessment, dated 9/22/17, signed by the RN Case Manager. Patient #9's initial assessment was not held within 48 hours of	G 514	Executive Director reviewed with staff policy 2.1.001 Admission process Focus of education admission/initial visits are made with 48 hours from referral unless there is a specific physician ordered start of care. Patient Care Managers will review all pending referrals with scheduler daily to ensure all referrals are appropriately scheduled to ensure admission within 48/hrs of referral or on physician ordered start of care date. Beginning May 7, 2018,Executive Director/designee to perform 5 SOC audits weekly to ensure timely admission of patients within 48/hrs of referral date or on physician's ordered start of care date has occurred X 8weeks or until 100% compliance is ensured X 2months. Executive Director responsible to implement plan.	5/7/18

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G 514	Continued From page 10 his referral to home health. His record did not include documentation of the reason his initial assessment was delayed. During an interview on 4/18/18 at 10:35 AM, the DON reviewed Patient #9's record and confirmed his initial assessment was performed 3 days after the referral order was received. The agency failed to ensure Patient #9's initial assessment was performed within 48 hours of his referral to home health.	G 514		
G 526	Content of the comprehensive assessment CFR(s): 484.55(c) The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information: This STANDARD is not met as evidenced by: Based on medical record review, policy review, and staff interview, it was determined the agency failed to ensure a comprehensive assessment was conducted for 1 of 13 patients (Patient #12) whose records were reviewed. This resulted in a failure to assess baseline wound measurements. It had the potential to interfere with the accurate assessment of patient progress in wound healing. Findings include: An agency policy, "WOUND ASSESSMENT, DOCUMENTATION, AND PHOTOGRAPHY," dated 9/01/17, stated: - "Upon initial visit ... all wounds will be assessed with appropriate documentation within the medical record." - "The assessment includes measurement of the length, width and depth ..."	G 526	Executive Director to review with staff policy 2.2001 Wound Assessment, Documentation, and photography. Education focus on obtaining baseline wound measurements on 5/14/18 ED will review with all clinicians the proper use of the ICC Wound Console in HCHB to enter all wound measurements including baseline wound measurements and ensure they are associated to the proper wounds utilizing the ICC job aides. Beginning 5/7/18 Executive Director/ designee will audit 8 wound charts per month X2months or until 100% compliance to ensure baseline measurements and weekly measurements are completed per policy . Executive director to implement plan.	5/14/18

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G 526	Continued From page 11 Patient #12 was a 60 year old female admitted to the agency on 3/30/18 with diagnoses of ESRD, insulin dependent OM, peripheral neuropathy, leg weakness, and cellulitis of the left index finger. She received SN, PT, OT, and aide services. Her record, including the POC, for certification period 3/30/18 to 5/28/18, was reviewed. Patient #12's SOC assessment, dated 3/30/18, signed by an RN, included an assessment of her left index finger and subsequent provision of wound care to the finger. The initial assessment did not include wound measurements. The first wound care measurements were documented during an SN visit, dated 4/13/18. The DON was interviewed on 4/18/18 at 3:10 PM. She reviewed Patient #12's record and confirmed there were no baseline wound measurements documented at the SOC. Patient #12's SOC assessment did not include Patient #12's wound care measurements.	G 526		
G 536	A review of all current medications CFR(s): 484.55(c)(5) 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 ELEMENT is not met as evidenced by: Based on medical record review, agnecy policy review, staff interview, and website review, it was determined the agency failed to ensure a comprehensive medication review was performed	G 536		

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	137019	A. BUILDING _____ B. WING _____	04/19/2018

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G 536	Continued From page 12 and potential significant drug interactions were identified for 2 of 13 patients (#4 and #10) whose records were reviewed. This failure resulted in incomplete patient medication assessments and had the potential for poor patient outcomes and increased risk of harm. Findings include: The agency's policy "PATIENT ASSESSMENT, INITIALAND REASSESSMENT" revised 2/01/18, stated "Upon admission and reassessments, the qualified clinician performs the following assessment activities and collects the following data: ...Review of all medications 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." The agency's policy "MONITORING MEDICATIONS" revised 2/01/18, stated "Compare medications patient is currently taking with medications ordered for the patient in order to identify and resolve discrepancies...The physician will be notified of discrepancies and documentation of notification must be evident in the medical record." 1. Patient #4 was an 83 year old female admitted to the agency on 3/23/18, with a primary diagnosis of injury to the right lower leg. Additional diagnoses included HTN and history of falling. She received **SN** services. Her record, including the POC, for the certification period 3/23/18 to 5/21/18, was reviewed. Patient #4's record included an "MD/SBAR COMMUNICATION," dated 3/24/18, entered by the RN Case Manager. The note stated	G 536	On 05/10/1, Executive Director to provide education to all clinical staff on policy2.1.002 Patient Assessment, Initial and Reassessment with education focus on review of all medications upon admission and reassessment to identify any potential adverse effects. Policy 10.008 Monitoring medications will be reviewed with all clinicians with focus on the requirement that all clinicians will participate in medication review and reconciliation process throughout the episode. Executive Director will review with all clinicians the Medication Reconciliation job aide and use of the Medication Review Questionnaire on every visit and expectations for maintaining a current and accurate medication list. Medication Reconciliation process to include physician notification of any medication discrepancies and/or duplications to avoid potential over dosing of medications. Beginning May 7th 2018 Executive director/designee will observe 1 home visit per week x8weeks or until 100% compliance achieved X 4 consecutive weeks to ensure medication accuracy. Executive Director to implement action plan.	5/10/18

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G 536	Continued From page 13 "SIGNIFICANT EVENT/PROBLEM: THERE ARE MEDICATION DISCREPANCIES FROM YOUR MEDICATION LIST TO WHAT THE PATIENT ACTUALLY HAS IN THE HOME." The note stated Patient #4 was not taking 4 medications that were on the physician's medication list and she was taking 3 medications that were not on the physician's medication list. Patient #4's record did not include documentation of a physician's response to the communication. It was unclear how it was determined what medications Patient #4 should take. During an interview on 4/19/18 at 8:00 AM, the RN Case Manager confirmed issues were identified during the review of Patient #4's medications at SOC, and the discrepancies were faxed to her physician. She confirmed there was no response from the physician and she did not follow up with the physician to determine what medications Patient #4 should take. The agency failed to ensure Patient #4's medication discrepancies were reconciled with her physician to determine what medications she should take. 2. Patient #10 was a 70 year old male admitted to the agency on 4/25/17, with a primary diagnosis of infection of a graft in his chest wall. Additional diagnoses included MRSA infection and adult failure to thrive. He received SN, PT, and OT services. Patient #10 was discharged from the agency on 5/01/17. His record, including the POC, for the certification period 4/25/17 to 6/23/17, was reviewed. Patient #10's POC and medication record included Acetaminophen 325 mg, 2 tablets every	G 536		

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G 536	Continued From page 14 4 hours as needed, and Hydrocodone-Acetaminophen 5-325 mg, 1 to 2 tablets every 4 hours as needed. Two tablets of each medication taken every 4 hours, as ordered, would result in an intake of 7800 mg or 7.8 grams of Acetaminophen in 24 hours. The U.S. Food and Drug Administration (FDA) website, accessed 4/23/18, stated "Advise patients not to exceed the acetaminophen maximum total daily dose (4 grams/day). Severe liver injury, including cases of acute liver failure resulting in liver transplant and death, has been reported with the use of acetaminophen. Educate patients about the importance of reading all prescription and OTC [over the counter] labels to ensure they are not taking multiple acetaminophen-containing products." Patient #1O's record did not include patient education related to the use of his Acetaminophen and Hydrocodone-Acetaminophen, to ensure he did not take more than 4 grams per day. During an interview on 4/18/18 at 10:00 AM, the DON reviewed Patient #1O's record and confirmed that the potential for Acetaminophen overdose was not identified by the agency. She confirmed there was not documentation of patient education regarding limiting the intake of Acetaminophen. The agency failed to identify potential adverse effects of Patient #1O's medications.	G 536		
G 572	Plan of care **CFR(s): 484.60(a)(1)**	G 572		

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G 572	Continued From page 15 Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure care followed the patients' written POC, for 2 of 13 patients (#5 and #11) whose records were reviewed. This failure had the potential to result in care not provided as ordered by the physician. Findings include: 1. Patient #11 was an 75 year old male admitted to the agency on 3/30/18 with a primary diagnosis of sepsis. Additional diagnoses included UTI and diabetes mellitus type 2. He received SN, PT, and OT services. His record, including the POC, for the certification period 3/30/18 to 5/28/18, was reviewed. Patient #11's POC included an order for PT visits 3 times a week for 1 week, effective 4/01/18. His record included a PT evaluation visit note, dated 4/02/18, signed by the Physical Therapist. Additionally, Patient #11's record included a PT visit note, dated 4/04/18, signed by the Physical Therapist. No additional PT visit was documented during the week of 4/01/18 to 4/07/18.	G 572	Executive Director to in-service staff on 5/17/18 Policy 2.1.007 Plan of Care and 2.1.017 Coordination of Care, from Admit through Discharge Education to focus on development of individualized Plan of Care and coordination of care throughout episode identifying patient's needs throughout care. Executive Director to review expectations with clinicians to read the entire patient plan of care prior to providing care to confirm that orders are implemented as written including obtaining oxygen saturation levels per physician orders. Physician notification of any alterations to the plan of care including missed visits impacting ordered frequency will occur. Scheduler will verify weekly that physician notification of all missed visits which occurred during the week has occurred. Beginning May 7, 2018, the Executive Director/Designee will review 8 clinical records/month for 3 months or until 100% compliance achieved in ensuring that plan of care orders have been followed. Executive Director is responsible for implementing the plan of correction	5/17/18

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G 572	Continued From page 16 Patient #11 recieved 2 PT visits when 3 PT visits were ordered for the week of 4/01/18 to 4/07/18. The DON was interviewed on 4/18/18, beginning at 11:30 AM, and Patient #11's record was reviewed in her presence. She confirmed 3 PT visits were ordered and 2 PT visits were performed for the week of 4/01/18 to 4/07/18. Patient #11 did not receive PT visits as ordered on his POC. 2. Patient #5 was a 94 year old male admitted to the agency on 4/06/18, with a primary diagnosis of chronic kidney disease with heart failure. Additional diagnoses included CHF and history of falling. He received SN services. His record, including the POC, for the certification period 4/06/18 to 6/04/18, was reviewed. Patient #5's POC included an order for SN to obtain his oxygen saturation level on room air every visit. Patient #5's record included an SN visit note, dated 4/13/18, signed by the LPN. The SN visit note documented Patient #5's oxygen saturation level was obtained while he was on 2 liters of oxygen and not on room air as ordered on the POC. The DON was interviewed on 4/18/18, beginning at 11:30 AM, and Patient #5's medical record was reviewed in her presence. She confirmed the LPN documented that she checked Patient #5's oxygen saturation on 2 liters of oxygen and not on room air as ordered on the POC. The LPN failed to follow the POC when checking	G 572		

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G 572	Continued From page 17 Patient #5's oxygen saturation.	G 572		
G 574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) (2) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. This ELEMENT is not met as evidenced by: Based on agency policy, medical record review, observation, and staff interview, it was determined the agency failed to ensure POCs	G 574	On May 10, 2018, the Executive Director to provide education to all clinicians on policy # 2.1.007 Plan of Care with emphasis on the requirement to include ALL supplies and equipment included in the patient's plan of care. Patient #1 obtained updated order to ensure it included incontinence pads, a weight scale and pulse oximeter sent to physician 4/17/18. Patient# 8 obtain updated order 5/3/18 for bedside commode, elevated toilet seat, and tub chair. Patient # 12 updated order sent 5/3/18 to POC to include glucometer or other diabetic supplies, bedside commode, cane and elevated toilet seat.or , tub chair. Patient #11 updated order to POC to include glucometer and diabetic supplies sent 5/3/18 Beginning May 7th 2018 Executive director/designee will observe 1 home visit per week x8weeks or until 100% compliance achieved X 4 consecutive weeks to ensure accuracy of equipment/supplies listed on the plan of care. Executive Director to implement action plan.	5/10/18

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G 574	Continued From page 18 included relevant equipment and supplies for 4 of 13 patients (#1, #8, #11, and #12) whose records were reviewed. This had the potential to interfere with coordination of patient care. Findings include: An agency policy, "PLAN OF CARE (POC)," revised 1/01/18, stated: "The POC includes:..equipment and supplies." This policy was not followed. Examples include: 1. Patient #1 was a 74 year old female admitted to the agency on 3/08/18 with diagnoses of pneumonia, COPD, ASHD, hypertension, CHF, Type 2 DM, and dependency on supplemental oxygen. She received SN, PT, OT, ST, **MSW,** and aide services. Her record, including the POC, for certification period 3/08/18 to 5/06/18, was reviewed. A visit was made to Patient #1's home to observe aide care. Patient #1 was observed to be sitting on incontinence pads. During the visit, Patient #1 stated she "leaked" on the pad. The aide was observed to change the pad. A weight scale was observed in her living room. Patient #1 was using a pulse oximeter to monitor her own oxygen saturation levels. Patient #1's POC did not include incontinence pads, a weight scale, or a pulse oximeter. During an interview on 4/18/18 at 1:35 PM, the DON reviewed Patient #1's record and confirmed the supplies and equipment were relevant to Patient #1 care and not included on her POC. 2. Patient #8 was an 81 year old female admitted	G 574		

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G 574	Continued From page 19 to the agency on 10/18/17 with diagnoses of muscle weakness, HTN, COPD, major depressive disorder, and atrial fibrillation. She received SN and PT services. Her record, including the POC, for certification period 10/18/17 to 12/16/17, was reviewed. A PT evaluation of Patient #8, dated 10/20/17, included her use of a bedside commode, elevated toilet seat, and tub chair. Patient #S's POC for certification period 10/18/17 to 12/16/17 did not include the bedside commode, elevated toilet seat, or tub chair. During an interview on 4/18/18 at 2:25 PM, the DON reviewed Patient #S's POC and confirmed the DME had not been included in her POC. 3. Patient #12 was a 60 year old female admitted to the agency on 3/30/18 with diagnoses of ESRD, insulin dependent DM, peripheral neuropathy, leg weakness, and cellulitis of the left index finger. She received SN, PT, OT, and aide services. Her record, including the POC, for the certification period 3/30/18 to 5/28/18 was reviewed. The SOC visit, dated 3/30/18, signed by an RN, referenced Patient #12's use of a glucometer to monitor her blood sugars. A PT visit note, dated 4/02/18, referenced Patient #12's use of a bedside commode, cane, elevated toilet seat, and tub chair. The POC for certification period 3/30/18 to 5/28/18 did not include a glucometer or other diabetic supplies, a bedside commode, cane,	G 574		

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G 574	Continued From page 20 elevated toilet seat, or tub chair. The DON was interviewed on 4/18/18 at 3:10 PM. She reviewed Patient #12's record and confirmed the DME and supplies were not included on her POC. 4. Patient #11 was an 75 year old male admitted to the agency on 3/30/18 with a primary diagnosis of sepsis. Additional diagnoses included UTI and diabetes mellitus type 2. He received SN, PT, and OT services. His record, including the POC, for the certification period 3/30/18 to 5/28/18, was reviewed. Patient #11's medical record included an SOC assessment, dated 3/30/18, signed by the RN Case Manager. The SOC assessment stated in the narrative note section, Patient #11 demonstrated checking his blood sugars. Patient #11's POC did not include his glucometer or diabetic supplies needed to check his blood sugar. The DON was interviewed 4/18/18, beginning at 11:30 AM, and patient #11's medical record was reviewed in her presence. She confirmed Patient #11's POC did not include his glucometer and diabetic supplies. The agency failed to ensure all DME and supplies were listed on the POCs for Patients #1, #8, #11, and #12.	G 574		
G 580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician.	G 580		

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G 580	Continued From page 21 This ELEMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure medications were taken only as ordered by the physician for 1 of 13 patients (Patient #9) whose records were reviewed. This failure resulted in medications that were not consistent with the physician orders, and had the potential to negatively impact the safety and quality of patient care. Findings include: Patient #9 was an 83 year old male admitted to the agency on 9/22/17, with a primary diagnosis of dizziness. Additional diagnoses included gastroparesis, depression, history of falling, and dependence on supplemental oxygen. He received SN, PT, OT, MSW, and aide services. Patient #9 was discharged from the agency on 11/14/17. His record, including the POC, for the certification period 9/22/17 to 11/20/17, was reviewed. Patient #9's record included a physician order request dated 9/26/17, signed by the Physical Therapist. It stated "MEDICATION FOUND IN HOME, PRESCRIBED DURING HOSPITALIZATION: HYDRO/APAP [Hydrocodone-Acetaminophen, a narcotic analgesic] 7.5/325 MG 1 TAB EVERY 6 HRS PRN PAIN." Below the order was handwritten "Discontinue" with the physician's signature, dated 10/02/17. Patient #9's medication report included Hydrocodone-Acetaminophen 7.5-325 mg with a start date of 9/26/17. The medication did not include an end date. The medication was not discontinued on 10/02/17, as ordered by the physician. Patient #9's record did not include	G 580	Executive Director (ED) reviewed with staff Policy 2.1.008 Physician's orders focus on medications, treatments, diagnostic studies will be administered under the direction of ordering Physician and appropriate documentation Implementation of orders. ED will reviewed with clinicians the need to include all physician ordered end dates for medications on the medication list included in the plan of care and to provide patient education pertaining to physician ordered end dates. Beginning, May 7, 2018 Executive Director/designee to audit 5 charts weekly x8week or until 100% compliance is achieved to ensure accurate completion of order and implementation of orders including medication end dates listed on the plan of care. Executive Director to implement action plan.	5/10/18

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G 580	Continued From page 22 documentation he was instructed to discontinue the medication. During an interview on 4/18/18 at 10:35 AM, the DON reviewed Patient #9's record and confirmed the medication was not discontinued as ordered by his physician. The agency failed to ensure Patient #9's medications were taken as ordered by his physician.	G 580		
G 706	Interdisciplinary assessment of the patient CFR(s): 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; This ELEMENT is not met as evidenced by: Based on medical record review, policy review, and staff interview, it was determined the agency failed to ensure ongoing interdisciplinary assessment of 3 of 13 patients (#4, #8, and #9) whose records were reviewed. This failure resulted in an inability to accurately assess progress toward wound resolution and ongoing need for aide services. Findings include: 1. An agency policy, "WOUND ASSESSMENT, DOCUMENTATION, AND PHOTOGRAPHY," dated 9/01/17, stated: "Unless otherwise ordered by the physician, the Registered Nurse will assess wounds at least: - Weekly for patient receiving negative pressure wound therapy, receiving daily wound care performed by the agency, have an infected wound, or have stage IV pressure injury. - Every other week for patients receiving wound care by the agency at a frequency less than	G 706	Executive Director reviewed with staff policy 2.1.017 Coordination of Care, From Admit through Discharge on 5/3/18 Education focus regarding coordination of care with physician throughout care and coordination among disciplines to ensure appropriate patient care. Education to staff communication to all involved in care should include but not limited to significant changes in patient's condition, new or worsening symptoms and or changes to the Plan of Care. Executive Director to review with Clinician agencies policy 2.2001 on 5/3/18 Wound Assessment Documantation, and photography with a focus on accurate measuring and documentation of wound in Integumentary Command Center.	5/10/18

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G 706	Continued From page 23 daily." This policy was not followed. Examples include: a. Patient #8 was an 81 year old female admitted to the agency on 10/18/17 with diagnoses of muscle weakness, HTN, COPD, major depressive disorder, and atrial fibrillation. She received SN and PT services. Her record, including the POC, for the certification period 10/18/17 to 12/16/17, was reviewed. SN visits, dated 10/25/17, 10/28/17, 10/31/17, 11/07/17, 11/09/17, 11/14/17, and 11/16/17, documented wound care was provided to a pressure ulcer on Patient #S's buttock. Wound care measurements were documented in SN visit notes in Patient#8's record on 10/25/17, 10/28/17, and 10/31/17. Wound care was provided but no wound measurements were taken during the remaining SN visits, dated 11/07/17, 11/09/17, 11/09/17, 11/14/17, and 11/16/17. The SN visit note, dated 11/20/17, documented the wound was "completely epithelialized" (closed). There was a 3 week period from the time of last measurement until the time the wound was considered resolved and wound care was discontinued. The wound was not measured every 2 weeks in accordance with agency policy. The DON was interviewed on 4/18/18 at 2:25 PM. She reviewed reviewed Patient #S's record and stated some of the visit notes documented "unable" to measure. She stated there was no explanation as to why wound measurements could not be taken and it was her expectation that	G 706	Beginning May 7th/2018 Executive Director//Designee will audit 4 charts weeklyX 8weeks or until 100% compliance for 4 weeks consecutively to monitor coordination of care. Executive Director responsible to implement action plan	

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G 706	Continued From page 24	G 706		

wounds be measured weekly.

Patient #S's pressure ulcer was not measured in accordance with agency policy and DON expectation.

b. Patient #4 was an 83 year old female admitted to the agency on 3/23/18, with a primary diagnosis of injury to the right lower leg. Additional diagnoses included HTN and history of falling. She received SN services. Her record, including the POC, for the certification period 3/23/18 to 5/21/18, was reviewed.

Patient #4's POC included orders for wound care to her right lower leg, using negative-pressure wound therapy, a therapeutic technique using a vacuum dressing to promote healing in acute or chronic wounds. Her record included measurements of her wound documented on 3/23/18, and 11 days later, on 4/03/18. No wound measurements were documented on the SN visit notes dated 3/27/18 and 3/30/18.

During an interview on 4/19/18 at 8:00 AM, the RN Case Manager reviewed Patient #4's record and confirmed no wound measurements were documented between 3/23/18 and 4/03/18.

Patient #4's wound was not measured in accordance with agency policy and DON expectation.

2. Patient #9 was an 83 year old male admitted to the agency on 9/22/17, with a primary diagnosis of dizziness. Additional diagnoses included gastroparesis, depression, history of falling, and dependence on supplemental oxygen. He received SN, PT, OT, MSW, and aide

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G 706	Continued From page 25 services. Patient #9 was discharged from the agency on 11/14/17. His record, including the POC, for the certification period 9/22/17 to 11/20/17, was reviewed. Patient #9's record included an SOC comprehensive assessment, dated 9/22/17, signed by the RN Case Manager. The assessment documented he required assistance with dressing and bathing. Patient #9's POC included an order for aide visits 2 times a week for 4 weeks, beginning 9/24/17, and ending 10/21/17. His record included an SN visit note, dated 10/16/17, signed by the RN Case Manager. The note stated he required assistance with his personal care. The last aide visit was documented on 10/20/17. His record included an SN visit note, dated 10/27/17, signed by an RN. The note stated the patienUcaregiverwere unable to perform his personal care. It was unclear how Patient #9's personal care needs would be met without aide services. During an interview on 4/18/18 at 10:35 AM, the DON reviewed Patient #9's record and confirmed it did not include a reassessment to determine his need for continued aide services. The agency failed to ensure Patient #9 was assessed to determine his need for continued aide services after the original order for aide visits expired.	G 706		
G 718	Communication with physicians CFR(s): 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners	G 718		

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G 718	Continued From page 26 (as appropriate) related to the current plan of care; This ELEMENT is not met as evidenced by: Based on medical record review, policy review, and staff interview, it was determined the agency failed to ensure appropriate reporting and communication occurred related to significant symptoms for 3 of 13 patients (#5, #8, and #10) whose records were reviewed. This had the potential to interfere with quality and safety of patient care and the opportunity to adjust the POC to meet patient needs. Findings include: 1. An agency job description, "Physical Therapist Assistant," revised 4/01/18, stated the PTA was "to notify the physical therapist of changes in patient's status, including all untoward patient responses immediately." Patient #8 was an 81 year old female admitted to the agency on 10/18/17 with diagnoses of muscle weakness, HTN, COPD, major depressive disorder, and atrial fibrillation. She received SN and PT services. Her record, including the POC, for certification period 10/18/17 to 12/16/17, was reviewed. The PTA did not notify the Physical Therapist of changes in Patient #S's condition. Examples include: a. A PTA visit note, dated 11/06/17, documented Patient #S's blood pressure as 160/108 and included the comment "PATIENT HAS COMPLAINTS OF PRESSURE AND NUMBNESS IN CHEST AND LUE." Under the section of the note titled "CARE COORDINATION," a "NO" response was	G 718	Executive Director/Designee provided inservice to all staff on May 3, 2018 regarding policies 2.1.017 Coordination of Care from Admit through Discharge and Physician Orders 2.1.008 Education provided regarding reporting significant changes of patient condition timely to the physician and all disciplines involved with care. Process for care coordination reviewed with all LPNs, aides, Physical and Occupational Therapists and Assistants. Symptoms, abnormal findings and changes warranting immediate notification to the patient care manager and to supervising RN, PT, OT reviewed. Appropriate documentation of this communication in the clinical record reviewed. Therapy assistants, LPN and Home Health aide will report findings to the RN case manager AND to Physical Therapist or Occupational Therapist supervising the patient's care. All clinicians will report within 24 hours findings to the patient care manager or Executive Director by fax , telephone or through coordination notes.	5/10/18

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G 718	Continued From page 27 documented after the statement "INDICATE IF YOU COMMUNICATED WITH OTHER DISCIPLINES/INDIVIDUALS INVOLVED IN THIS CASE." There was no documentation the supervising Physical Therapist was alerted to Patient #S's condition. b. A PTA visit note, dated 11/16/17, documented Patient #S's blood pressure as 140/100 and included the comment "PATIENT REPORTS HAVING SOB." Additional PTA entries, dated 11/16/17, related to Patient #S's condition and POC: - "PATIENT REPORTS THAT SHE IS FEELING WEAKAND COMPLAINS OF SHORTNESS OF BREATH, STATES THAT HER BLOOD PRESSURE HAS BEEN HIGH ALL DAY AND YESTERDAY AS WELL. STATES THAT ASSISTED LIVING FACILITY NURSING STAFF HAS RECOMMENDED SHE GO TO ER, BUT PATIENT REPORTS REFUSING." - "PATIENT PRESENTED THE DAY WITH ELEVATED BP AND INCREASED WEAKNESS DUE TO FATIGUE. PATIENT WAS EDUCATED ON HOME EXERCISE PROGRAM AND PROVIDED WRITTEN INSTRUCTIONS TO BE PERFORMED TWICE A DAY TO IMPROVE BILATERAL LOWER EXTREMITY STRENGTHENING. DOCTOR'S OFFICE WAS NOTIFIED OF HYPERTENSIVE READINGS AND THERAPY WAS KEPT TO A MINIMAL LEVEL OF EXERTION." - "CONTINUE WITH CURRENT PLAN OF	G 718	Occurrence reported 5/3/18 for patient # 8 entered Corrective Action Plan Implemented on 5/2/18 for PTA involved in patient #10 care started for not adhering to Care coordination Policy 2.1.017 Beginning May 7, 2018, Executive Director to review 8 clinical records month to ensure proper documentation of symptoms and changes in patient condition have been reported to the supervisory nurse/therapist and physician Care coordination will be demonstrated and confirmed that documentation matches actions by supervising PT/Patient Care Manager. 3 occupational therapy assistant or physical therapy assistant notes will be reviewed each week X 4weeks or until 100% compliance X four consecutive weeks by regional therapy coordinator ensuring adequate care coordination of patient changes in condition/concerns has occurred. Executive Director responsible to implement action.plan	

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G 718	Continued From page 28 CARE. PROGRESS TOWARDS FUNCTIONAL GOALS AS PATIENT TOLERATED WITH EMPHASIS ON STANDING BALANCE AND ACTIVITY TOLERANCE TO IMPROVE GAIT FUNCTION." Under the section of the note titled "CARE COORDINATION," a "NO" response was documented after the statement "INDICATE IF YOU COMMUNICATED WITH OTHER DISCIPLINES/INDIVIDUALS INVOLVED IN THIS CASE." There was no documentation the supervising PT was alerted to Patient #S's condition. c. A PTA visit note, dated 11/21/17, documented Patient #S's blood pressure as 138/100. Additional PTA entries, dated 11/21/17, related to Patient #S's condition: - "PATIENT PRESENTED TODAY WITH INCREASED WEAKNESS, DECREASED BALANCE AWARENESS AND NEEDING INCREASED LEVEL OF ASSISTANCE. PATIENT PRESENTED WITH ELEVATED BP AND STATES THAT HER BP HAS BEEN 'HIGH FOR AWHILE.' SKILLED THERAPY FOCUSED ON TRANSFER TRAINING, BUT HAD TO DISCONTINUE DUE TO HYPERTENSION." Under the section of the note titled "CARE COORDINATION," a "NO" response was documented after the statement "INDICATE IF YOU COMMUNICATED WITH OTHER DISCIPLINES/INDIVIDUALS INVOLVED IN THIS CASE."	G 718		

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G 718	Continued From page 29 There was no documentation the supervising Physical Therapist was alerted to Patient #S's condition. The PTA was interviewed on 4/18/18 at 10:20 AM. He confirmed the notes stated no coordination occurred. He stated he generally wrote coordination notes elsewhere but he could not access the record to view them because it was a closed record. He stated he regularly coordinated with team members. When asked who he reported significant findings to, he stated it depended, sometimes he coordinated with the ALF RN, sometimes he called the physician directly, sometimes he called the office RN, and sometimes he contacted the Physical Therapist. As it related to the 11/06/17 visit with Patient #8, the PTA stated he thought he reported to the ALF RN and that he must have meant to write "No chest pain." He thought the report of chest pain was a "typo." As it related to the 11/21 /17 visit with Patient #8, the PTA stated he should have sent an MD/SBAR communication note to the physician but he did not. The DON was interviewed on 4/18/18 at 2:25 PM. She reviewed Patient #S's record, and she confirmed there was no documentation the PTA had notified the supervising Physical Therapist of findings identified at Patient #S's visits. She stated there was documentation in the record Patient #S's blood pressure on 11/06/17 (but not chest pain) had been reported to the physician. She stated there was no documentation in Patient #S's record the PTA had reported findings to agency staff related to the visit findings on	G 718		

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G 718	Continued From page 30 11/21/17. The PTA did not communicate significant findings related to Patient #8 with the supervising Physical Therapist in accordance with agency policy. 3. Patient #10 was a 70 year old male admitted to the agency on 4/25/17, with a primary diagnosis of infection of a graft in his chest wall. Additional diagnoses included MRSA infection and adult failure to thrive. He received SN, PT, and OT services. Patient #10 was discharged from the agency on 5/01/17. His record, including the POC, for the certification period 4/25/17 to 6/23/17, was reviewed. Patient #10's POC included an order to notify his physician of a heart rate greater than 110 beats per minute. His record included a PT visit note dated 4/28/17, signed by a PTA. The note documented a heart rate of 113 beats per minute. There was no documentation the PTA notified the Physical Therapist or the RN Case Manager of Patient #10's elevated heart rate. During an interview on 4/18/18 at 10:00 AM, the DON confirmed there was no documentation of communication with Patient #10's Physical Therapist or RN Case Manager regarding his elevated heart rate on 4/28/17. Patient #10's elevated heart rate was not communicated to his Physical Therapist or RN Case Manager. 3. Patient #5 was an 94 year old male admitted to the agency on 4/06/18, with a primary diagnosis of chronic kidney disease with heart failure. Additional diagnoses included CHF and	G 718		

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G 718	Continued From page 31 history of falling. He received SN services. His record, including the POC, for the certification period 4/06/18 to 6/04/18, was reviewed. Patient #5's medical record included an SN visit note, dated 4/13/18, signed by an LPN. The note stated Patient #5 had discoloration noted in his toes related to circulation. The LPN did not document if she contacted Patient #5's physician or RN Case Manager regarding her abnormal findings. The DON was interviewed on 4/18/18, beginning at 11:30 AM, and Patient #5's medical record was reviewed in her presence. She confirmed the LPN did not document she contacted Patient #5's physician or RN Case Manager regarding her findings. The LPN failed to communicate Patient #5's abnormal findings to her physician and RN Case Manager.	G 718		
G 800	Services provided by HH aide CFR(s): 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. This ELEMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, it was determined the agency failed to ensure the aide limited services to those activities included in the aide care plan for 1 of 1 patient (Patient #1) whose aide care was observed in the home. This failure had the	G 800		

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G 800	Continued From page 32 potential to interfere with patient safety. Findings include: Patient #1 was a 74 year old female admitted to the agency on 3/08/18 with diagnoses of pneumonia, COPD, ASHD, HTN, CHF, Type 2 OM, and dependency on supplemental oxygen. She received SN, PT, OT, ST, **MSW**, and aide services. Her record, including the POC, for the certification period 3/08/18 to 5/06/18, was reviewed. A visit was made to Patient #1's home to observe aide care. The aide was observed to conduct activities beyond the scope of the aide POC. She was observed to educate Patient #1 on how to breathe when her oxygen saturation levels dropped. The aide asked Patient #1 if she had a mammogram and told Patient #1 she had a breast lump. The aide instructed Patient #1 not to put lotion between her toes because she was diabetic and it could cause bacteria buildup. In response to Patient #1's request for food, the aide warmed her up soup and brought her soup, yogurt, and fruit. The aide POC did not include instructions or authorization to prepare food or to educate Patient #1. During an interview on 4/18/18 at 1:35 PM, the DON stated it was not the role of the aide to educate patients or to provide food unless it was on the POC. The agency failed to ensure aide services were provided for Patient #1 within the scope of the aide care plan.	G 800	Executive Director reviewed with staff appropriate use of Home Health Aide to ensure our patient's have all the service that they are allowed and reviewed documentation of implementing and updating Home Health Aide Care Plan on 5/3/18 Executive directive implemented corrective action for success plan to begin 5/7/18 for Home Health aide for failure to follow plan of care and practicing outside scope of practice Beginning May 7th 2018 Executive director/designee will observe 1 home visit with home health aide per week x8weeks or until 100% compliance achieved X 4 consecutive weeks to ensure POC is followed Executive Director responsible to implement action. plan	5/10/18

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G1022	Continued From page 33	G1022		
G1022	Discharge and transfer summaries CFR(s): 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. This ELEMENT is not met as evidenced by: Based on medical record review, agency policy review, and staff interview, it was determined the agency failed to ensure a completed discharge summary was sent for 1 of 5 patients (Patient #13) who were discharged from the agency and whose records were reviewed. This had the potential to interferewith the continuity of care for Patient #13. Findings include: An agency policy, "PATIENT DISCHARGE/TRANSFER PROCESS," dated 3/01/18, stated: "A discharge summary including admission and discharge dates, reason for admission to home health, reason for discharge, services provided to the patient, patient's condition at time of discharge, a brief summary of care provided, progress towards goals, a list of community resources, or referrals made, along with a current	G1022	Executive Director educated staff on 5/10/18 on Patient Discharge transfer process 2.1.004 A qualified clinician coordinates the discharge or transfer with the patient/legal representative and physician prior to discharge or as soon as possible and a comprehensive assessments are completed at transfer and discharge. Executive Director reviewed the proper process for physician and facility notification of patient discharge/transfer via completion of the discharge/transfer summary. Intra-agency processes reviewed with the team to ensure timely completion of the discharge/summaries. Beginning May 7, 2018 Executive Director/designee will audit 4 discharged charts weekly x8weeks x 4 weeks or until 100% compliance achieved x 4 consecutive weeks. Executive Director responsible to implement action plan.	5/10/18

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G1022	Continued From page 34 medication list is sent to the physician or other healthcare professional responsible for care after discharge from the agency within 5 business days of patients discharge." Patient #13 was a 77 year old female admitted to the agency on 1/14/18, with a primary diagnosis of COPD. Additional diagnoses included CHF and history of falling. She received SN, PT, OT, and MSW services. Her record, including the POC, for the certification period of 1/14/18 to 3/14/18, was reviewed. Patient #13's record included a RN note, dated 2/16/18, signed by the RN Case Manager. The note stated Patient #13 was admitted to the hospital on 2/16/18. Patient #13's medical record did not indicate what day she was discharged from the agency. Patient #13's medical record did not include a transfer or discharge summary. The DON was interviewed 4/18/18, beginning at 11:30 AM, and Patient #13's record was reviewed in her presence. She confirmed Patient #13 was discharged from the agency. She also confirmed Patient #13's record did not include a transfer or discharge summary. The agency failed to complete a transfer or discharge summary for Patient #13.	G1022		