IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
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August 30, 2018

Cypress Cooper, Administrator
Idaho Home Health & Hospice
222 Shoshone Street East
Twin Falls, ID 83301

RE: Idaho Home Health & Hospice, Provider #137014

Dear Mr. Cooper:

Based on the survey completed at Idaho Home Health & Hospice, on August 16, 2018, by our staff, we have determined Idaho Home Health & Hospice is out of compliance with the Medicare Home Health Agency (HHA) Condition of Participation of **Skilled Professional Services (42 CFR 484.75)**. To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Idaho Home Health & Hospice, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction contains the following elements:

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

Such corrections must be achieved and compliance verified by this office, before September 30, 2018. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than September 22, 2018.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **September 10, 2018.**

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

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

This request must be received by **September 10, 2018**. If your request for informal dispute resolution is received after **September 10, 2018,** the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately.

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

Sincerely,

Dennis Kelly RN

DENNIS KELLY, RN, Supervisor
Non-Long Term Care

DK/pmt
Enclosures

ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Patrick Thrift, Survey & Certification Manager Region X
Julius Bunch, Certification & Enforcement Manager Region X

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137014	A. BUILDING _____ B. WING _____	08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO HOME HEALTH & HOSPICE	222 SHOSHONE STREET EAST TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your agency, conducted on 8/13/18 to 8/16/18. Surveyors conducting the survey were: Nancy Bax, RN, BSN, HFS, Team Lead Gary Guiles, RN, HFS James Brown, RN, HFS Acronyms used in this report include: ADLs - Activities of Daily Living ASHD - Arteriosclerotic Heart Disease CABG - Coronary Artery Bypass Graft CHF - Congestive Heart Failure COPD - Chronic Obstructive Pulmonary Disease DM - Diabetes Mellitus ED - Executive Director EMR - Electronic Medical Record HTN - Hypertension kgs - kilograms lbs - pounds LPN - Licensed Practical Nurse MD - Medical Doctor MSW - Medical Social Work OT - Occupational Therapy POC - Plan of Care PRN - As Needed PT - Physical Therapy PTA - Physical Therapy Assistant RN - Registered Nurse RNCM - Registerd Nurse Case Manager ROC - Resumption of Care SN - Skilled Nursing SNF - Skilled Nursing Facility SOB - Shortness of Breath SOC - Start of Care	G 000	RECEIVED SEP 10 2018 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bonita Buell, RN	Executive Director	9/7/2018

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 ST - Speech Therapy UTI - Urinary Tract Infection	G 000		
G 412	Written notice of patient's rights CFR(s): 484.50(a)(1)(i) Written notice of the patient's rights and responsibilities under this rule, and the HHA's transfer and discharge policies as set forth in paragraph (d) of this section. Written notice must be understandable to persons who have limited English proficiency and accessible to individuals with disabilities; This ELEMENT is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure patients were provided a written notice of patients' rights and responsibilities in advance of furnishing care to the patient for 2 of 16 patients (#10 and #17) whose SOC records were reviewed. Failure to meet this requirement had the potential to result in patients not being aware of all their rights. Findings include: 1. Patient #17 was a 93 year old male, admitted to the agency on 6/13/18, with a primary diagnosis of CHF. Additional diagnoses included cardiomyopathy, pleural effusion, and atrial fibrillation. He received SN, PT, and OT services. His record, including the POC, for the certification period 6/13/18 to 8/11/18, was reviewed. Patient #17's record included an OT evaluation, dated 6/13/18 beginning at 12:56 PM, signed by the Occupation Therapist. No patient contact was documented prior to the OT evaluation. The evaluation note did not document Patient #17 was given written notice of rights and responsibilities prior to the OT evaluation.	G 412		

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G 412	Continued From page 2 Patient #17's record included an SOC comprehensive assessment, dated 6/13/18 beginning at 2:11 PM, signed by the RNCM. The assessment stated patient rights and responsibilities were reviewed with Patient 17, and his signature was obtained. During an interview on 8/16/18 at 2:05 PM, the ED reviewed Patient #17's SOC paperwork and confirmed it was completed by the RNCM during the SOC assessment. She stated the OT visit occurred prior to the SOC comprehensive assessment and Patient #17 did not receive written notice of rights and responsibilities prior to the OT evaluation. The agency failed to ensure patients were given a written copy of their rights and responsibilities prior to the initiation of care. 2. Patient #10 was a 93 year old male, admitted to the agency on 8/09/18, with a primary diagnosis of pneumonia. Additional diagnoses included heart disease, and depression. He received SN, PT, OT and aide services. His record, including the POC, for the certification period 8/09/18 to 10/07/18, was reviewed. Patient #10's record included a PT evaluation, dated 8/09/18 beginning at 1:27 PM. The evaluation note did not document Patient #10 was given written notice of rights and responsibilities prior to the PT evaluation. Patient #10's record included an SOC comprehensive assessment, dated 8/10/18 beginning at 11:42 AM. The assessment stated patient rights and responsibilities were reviewed	G 412		

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G 412	Continued From page 3 with Patient 10, and his signature was obtained. During an interview on 8/15/18 at 9:15 AM, the ED reviewed Patient #10's medical record. She stated the PT visit occurred prior to the SOC comprehensive assessment and Patient #10 did not receive written notice of rights and responsibilities prior to the PT evaluation. The agency failed to ensure Patient #10 was given a written copy of his rights and responsibilities prior to the initiation of care.	G 412		
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 all assessments; (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 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	G 434		

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G 434	Continued From page 4 interview, it was determined the agency failed to ensure patients were given the opportunity to be involved in their POC, and consent to services prior to the initiation of services for 3 of 16 patients (#10, #12, and #17) whose SOC records were reviewed. This failure had the potential to result in patient receiving services without being informed of and consenting to the services. Findings include: 1. Patient #17 was a 93 year old male, admitted to the agency on 6/13/18, with a primary diagnosis of CHF. Additional diagnoses included cardiomyopathy, pleural effusion, and atrial fibrillation. He received SN, PT, and OT services. His record, including the POC, for the certification period 6/13/18 to 8/11/18, was reviewed. Patient #17's record included an OT evaluation, dated 6/13/18 beginning at 12:56 PM, signed by the Occupational Therapist. No patient contact was documented prior to the OT evaluation. The evaluation note did not document Patient #17 was informed of, or given the opportunity to refuse or consent to care, prior to the OT evaluation. Patient #17's record included an SOC comprehensive assessment, dated 6/13/18 beginning at 2:11 PM, signed by the RNCM. His record included an "ADMISSION CONSENT" form, dated 6/13/18, electronically signed by the RNCM and Patient #17. During an interview on 8/16/18 at 2:05 PM, the ED reviewed Patient #17's "ADMISSION CONSENT" form and confirmed it was completed by the RN during the SOC comprehensive assessment. She stated the OT visit occurred prior to the SOC assessment and Patient #17 did	G 434		

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G 434	Continued From page 5 not give consent for care prior to the initiation of the OT visit. The agency failed to ensure patients consented to care prior to the initiation of care. 2. Patient #12 was a 79 year old female, admitted to the agency on 6/29/18, with a primary diagnosis of CHF. Additional diagnoses included COPD and morbid obesity. She received SN, PT, ST, and MSW services. Her record, including the POC, for the certification period 6/29/18 to 8/27/18, was reviewed. Patient #12's record included an SOC comprehensive assessment, dated 6/26/18, signed by the RNCM. The assessment stated she lived alone and did not receive assistance from persons other than the agency staff. The assessment stated Patient #12 required assistance of another person for bathing and putting on upper body clothing and was unable to put on lower body clothing by herself. Her POC did not include home health aide services. There was no documentation that Patient #12 was educated about or offered a home health aide to assist her with personal care. During an interview on 8/15/18 at 4:50 PM, the RNCM confirmed there was no documentation Patient #12 was offered home health aide services to assist her with personal care. Patient #12 was not given information about all services offered by the agency to allow her to participate in her POC. 3. Patient #10 was a 93 year old male, admitted to the agency on 8/09/18, with a primary	G 434		

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G 434	Continued From page 6 diagnosis of pneumonia. Additional diagnoses included heart disease, and depression. He received SN, PT, OT and aide services. His record, including the POC, for the certification period 8/09/18 to 10/07/18, was reviewed. Patient #10's record included a PT evaluation, dated 8/09/18 beginning at 1:27 PM. The evaluation note did not document Patient #10 was informed of, or given the opportunity to refuse or consent to care, prior to the PT evaluation. Patient #10's record included an SOC comprehensive assessment, dated 8/10/18 beginning at 11:42 AM. His record included an "ADMISSION CONSENT" form, dated 6/13/18, electronically signed by the RNCM and Patient #10. During an interview on 8/15/18 at 9:15 AM, the ED reviewed Patient #10's medical record. She stated Patient #10 did not consent to treatment prior to the PT evaluation. The agency failed to ensure Patient #10 gave his consent for treatment prior to providing services.	G 434		
G 440	Payment from federally funded programs CFR(s): 484.50(c)(7)(i, ii, iii, iv) Be advised of -- (i) The extent to which payment for HHA services may be expected from Medicare, Medicaid, or any 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	G 440		

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G 440	Continued From page 7 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 5 patients (Patient #4) for whom a Medicare Advantage Plan was the payer and whose SOC 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 #4 was an 81 year old male, admitted to the agency on 7/20/18, with a primary diagnosis of emphysema. Additional diagnoses included ASHD, insulin dependent DM, HTN, and morbid obesity. He received SN, PT, OT, ST, and aide services. His record, including the POC, for the certification period 7/20/18 to 9/17/18, was reviewed. Patient #4's record included a "Patient Information Report" with an entry dated 7/19/18, regarding his insurance coverage. The note stated his plan would pay 80% of his home health charges after his deductible of $183.00 was met,	G 440		

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G 440	Continued From page 8 until the remaining out of pocket of $4692.92 was met. Patient #4's record included a "Patient Consent" form, signed by him and an RN on 7/20/18. The form stated, "Payment for services received by the patient will be made from the following sources: Medicare Advantage Plan." The form stated "Since I am Self-pay or have Group/Private Insurance 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 lines next to deductible, co-insurance, co-pay, and out of pocket maximum were blank. There was no documentation Patent #4 was notified, prior to receiving services, of the potential charges he may have to pay for home health services, . During an interview on 8/16/18 at 11:15 AM, the ED confirmed Patient #4 was not informed of the potential charges he may have to pay for his services. She stated the agency was attempting to verify coverage for his services through the Veteran's Administration, but that had not been determined. The agency failed to ensure Patient #4 was notified, before care was initiated, of charges he may have to pay for home health services.	G 440		
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	G 536		

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G 536	Continued From page 9 drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This ELEMENT is not met as evidenced by: Based on record review, policy review, observation, and patient and staff interview, it was determined the agency failed to ensure medications were reconciled at the time of admission and a medication list was kept current and reconciled for 4 of 17 patients (#1, #3, #4, and #13) whose records were reviewed. These failures had the potential to compromise patient safety. Findings include: The agency's policy "Patient Assessment, Initial and 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." 1. Patient #1 was a 57 year old female, admitted to the agency on 12/10/17, with a primary diagnosis of quadriplegia. Additional diagnoses included stage 2 pressure ulcers on each buttock, anxiety disorder, asthma, morbid obesity, and opioid dependence. She received SN, PT, OT, and MSW services. Her record, including the POC, for the certification period 12/12/17 to 2/07/18, was reviewed. Patient #1's record included a "Client Medication Report" signed by the RNCM on 12/14/17. The allergies listed on the report included the antibiotics Ciprofloxacin and Amoxicillin. Patient	G 536		

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G 536	Continued From page 10	G 536		

#1's "Client Medication Report" included Ciprofloxacin 300 mg daily, with a start date of 12/13/17, for UTI prevention. It also included Amoxicillin-Potassium Clavulanate 875/125 mg twice daily, from 12/08/17 to 12/13/17, for infection. There was no documentation of physician contact to reconcile the medications with her documented allergies.

During an interview on 8/16/18 at 2:20 PM, the branch Clinical Director reviewed Patient #1's record and confirmed the antibiotic orders should have been reviewed and reconciled with her physician due to her documented allergies to the antibiotics.

Patient #1's medications and allergies were not reviewed and reconciled with her physician.

2. Patient #3 was a 56 year old female, admitted to the agency on 8/13/18, with a primary diagnosis of CHF. Additional diagnoses included morbid obesity, HTN, and DM type 2. Her referral information was reviewed, and her SOC comprehensive assessment completed by an RN was observed on 8/14/18.

A visit was made to Patient #3's home on 8/13/18 at approximately 4:30 PM, with the RNCM, to observe her SOC assessment. The RNCM started the visit, and began reviewing rights and responsibilities and consent for services. During this time, Patient #3 said she received a call from the pharmacy, stating there was a prescription ready for her to pick up. Patient #3 stated she did not know what medication it was. Approximately 15 minutes into the visit, prior to signing consent for services, Patient #3 stated she had been to the physician's office earlier in the day, was tired,

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G 536	Continued From page 11 and wanted to end the visit. The RNCM stated she would contact her the following day to arrange another visit. A visit was made to Patient #3's home on 8/14/18 at approximately 11:00 AM, with the RNCM, to observe her SOC assessment. The RNCM did not review and reconcile Patient #3's medications during the visit, to ensure she had all of her medications, and was taking them as ordered. During an interview on 8/16/18 at 9:15 AM, the RN who completed Patient #3's SOC assessment confirmed she did not review her medications during the visit on 8/14/18. She stated when she called Patient #3 prior to the visit, she stated she had taken her morning medications. Patient #3's RNCM failed to review her medications during her SOC comprehensive assessment. 3. Patient #4 was an 81 year old male, admitted to the agency on 7/20/18, with a primary diagnosis of emphysema. Additional diagnoses included ASHD, insulin dependent DM, HTN, and morbid obesity. He received SN, PT, OT, ST, and aide services. His record, including the POC, for the certification period 7/20/18 to 9/17/18, was reviewed. A visit was made to Patient #4's home on 8/14/18 at 2:00 PM, to observe an SN visit, completed by the RNCM. During the visit, a bottle of Norco, an opioid pain medication, was noted on the table. Patient #4 stated the Norco was prescribed for him to take as needed for tooth pain following an emergency room visit 3 weeks ago. Norco was not included on Patient #4's POC or medication	G 536		

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	137014	A. BUILDING _____ B. WING _____	08/16/2018

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G 536	Continued From page 12 list. During an interview on 8/16/18 at 11:15 AM, the ED confirmed Patient #4's POC and medication list were not updated to include Norco after his emergency room visit. Patient #4's POC and medication list did not include all medications he was taking. 4. Patient #13 was an 84 year old male who was admitted for home health services on 10/12/17 with a primary diagnosis of venous insufficiency. Other diagnoses included insulin dependent DM, lymphedema of his legs with chronic ulcers, and CHF. He was discharged on 2/08/18. Patient #13's POC for the certification period 10/12/17 to 12/10/17 stated he was to receive intermediate acting (NPH) Insulin 45 units 2 times a day and short acting (regular) Insulin 15 units 2 times a day. It also stated he had no known allergies. a. Patient #13 was hospitalized from 12/01/17 to 12/04/17 for cellulitis of his legs. The Discharge Summary from the hospital, dated 12/04/17 at 9:42 AM and faxed to the agency on 12/04/17 at 10:53 AM, stated Patient #13's NPH Insulin dose was changed to 50 units 2 times a day and his regular Insulin dose was changed to a sliding scale depending on the results of blood glucose testing. The agency's resumption of care orders for Patient #13, dated 12/07/17 at 10:35 AM, listed the old Insulin orders of 45 units and 15 units 2 times a day, instead of the new Insulin orders. The POC, for the certification period 12/11/17 to 2/08/18, also listed the old Insulin orders of 45 units and 15 units 2 times a day,	G 536		

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G 536	Continued From page 13 instead of the new Insulin orders. Patient #13's Insulin orders were not changed after hospitalization. b. The Discharge Summary from the hospital, dated 12/04/17 at 9:42 AM and faxed to the agency on 12/04/17 at 10:53 AM, stated Patient #13 was allergic to Gabapentin. This was not added to the agency's medical record. Patient #13's POC for the certification period 12/11/17 to 2/08/18 stated he had no known allergies. c. Patient #13's POC for the certification periods 10/12/17 to 12/10/17 and 12/01/17 to 2/08/18, stated he was to receive a high dose (80 mg) of the water pill, Lasix. Lasix causes the depletion of potassium from the body and often requires potassium replacement. Neither POC included a prescription for potassium. No documentation was present in Patient #13's record that the agency questioned the physician about a prescription for potassium or about lab work to check his potassium level. The Clinical Director for the Meridian Branch reviewed Patient #13's record on 8/16/18 beginning at 10:00 AM. She stated the Insulin dosage was not changed by the agency after he was hospitalized. She stated Patient #13's POC was not updated to include his Gabapentin allergy. She stated there was not documentation that the agency questioned his lack of a potassium order. The agency did not review of Patient #13's medications to identify potential problems.	G 536		
G 572	Plan of care	G 572		

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G 572	Continued From page 14 CFR(s): 484.60(a)(1) 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 5 of 17 patients (#6, #7, #13, #14, and #16) whose records were reviewed. This failure had the potential to result in care not provided as ordered by the physician. Findings include: 1. Patient #7 was a 74 year old male admitted to the agency on 7/28/18, with a a primary diagnosis of Parkinson's Disease. Additional diagnoses included essential HTN and chronic pain. He received SN, PT, OT, MSW, and aide services. His record, including the POC, for the certification period 7/28/18 to 9/25/18, was reviewed. Patient #7's record included an SN SOC assessment, dated 7/28/18, signed by the RNCM. There was no documented communication with Patient #7's physician to obtain approval for his SN POC. Patient #7's SN POC for the certification period 7/28/18 to 9/25/18, was not signed by the physician as of 8/15/18. SN visits were provided on 8/01/18, 8/03/18, 8/08/18, and	G 572		

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G 572	Continued From page 15 8/10/18, prior to physician approval of his SN POC. The ED was interviewed on 8/15/18, beginning at 4:05 PM, and Patient #7's record was reviewed in her presence. She confirmed there was no documentation of the RN contacting the MD for approval of the SN POC, and confirmed SN visits were provided prior to physician approval. Patient #7 received 4 SN visits prior to physician approval of his SN POC. 2. Patient #6 was a 79 year old female admitted to the agency on 5/21/18, with a primary diagnosis of paroxysmal atrial fibrillation. Additional diagnoses included CHF and DM type II. She received SN and PT services. Her record, including the POC, for the certification period 7/20/18 to 9/17/18, was reviewed. Patient #6's record included an SN recertification assessment, dated 7/16/18, signed by the RNCM. There was no documented communication with Patient #6's physician to obtain approval for her SN POC. Patient #6's SN POC for the certification period 7/20/18 to 9/17/18, was signed by the physician on 8/13/18. SN visits were provided on 7/24/18, 7/31/18, and 8/06/18, prior to physician approval of the SN POC. The ED was interviewed on 8/15/18, beginning at 4:05 PM, and Patient #6's record was reviewed in her presence. She confirmed there was no documentation the RN contacted the MD for approval of the SN POC, and confirmed SN visits were provided prior to physician approval. Patient #6 received 3 SN visits prior to physician	G 572		

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G 572	Continued From page 16 approval of her SN POC. 3. Patient #13 was a 84 year old male who was admitted for home health services on 10/12/17 with a primary diagnosis of venous insufficiency. He was discharged on 2/08/18. A comprehensive assessment visit was conducted by the RN on 10/12/17. Following this, Patient #13's POC for the certification period 10/12/17 to 12/10/17 was developed. It stated an SN was to conduct a visit to Patient #13 1 time a week for 1 week, 2 times a week for 4 weeks and 1 time a week for 4 weeks. The physician signed the POC on 11/09/17. Nursing visits to Patient #13 were documented on 10/16/17, 10/19/17, 10/26/17, 10/30/17, 11/02/17, and 11/06/17. A physician order for these visits was not documented. The Clinical Director for the Meridian Branch reviewed Patient #13's record on 8/16/18 beginning at 10:00 AM. She stated the record did not contain an order for the above 6 nursing visits. Patient #13 received 6 SN visits prior to physician approval of his POC. 4. Patient #14 was a 73 year old female who was admitted for home health services on 7/10/18 with a primary diagnosis of acute ischemia of her intestine. She was currently a patient as of 8/16/18. A comprehensive assessment visit was conducted by the RN on 7/10/18. Following this, Patient #14's POC for the certification period	G 572		

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G 572	Continued From page 17 7/10/18 to 9/7/18 was developed. It stated an SN was to conduct a visit to Patient #14 2 times a week for 2 weeks and 1 time a week for 7 weeks. The physician signed the POC on 7/26/18. Nursing visits to Patient #14 were documented on 7/12/18, 7/16/18, 7/20/18, and 7/24/18. A physician order for these visits was not documented. The Clinical Director for the Meridian Branch reviewed Patient #14's record on 8/15/18 beginning at 3:15 PM. She stated the record did not contain a referral order. She also stated an order for the above 4 nursing visits was not documented. Patient #14 received 4 SN visits prior to physician approval of her POC. 5. Patient #16 was an 86 year old male who was admitted for home health services on 7/19/18 with a primary diagnosis of sepsis. He was discharged on 8/15/18. A comprehensive assessment visit was conducted by the RN on 7/19/18. Following this, Patient #16's POC for the certification period 7/19/18 to 9/16/18 was developed. It stated an SN was to conduct a visit to Patient #16 2 times a week for 3 weeks and 1 time a week for 5 weeks. The physician signed the POC on 8/06/18. Nursing visits to Patient #16 were documented on 7/23/18, 7/25/18, 7/30/18, and 8/01/18. A physician order for these visits was not documented. The Clinical Director for the Meridian Branch	G 572		

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G 572	Continued From page 18 reviewed Patient #16's record on 8/15/18 beginning at 3:15 PM. She stated the record did not contain a referral order. She also stated an order for the above 4 nursing visits was not documented. Patient #16 received 4 SN visits prior to physician approval of his POC.	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	G 574		

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G 574	Continued From page 19 directives; and (xvi) Any additional items the HHA or physician may choose to include. This ELEMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure the POC was accurate and addressed all pertinent interventions, safety measures, treatments, and supplies, for 2 of 17 patients (#1 and #13) whose records were reviewed. This failure resulted in incomplete POCs and had the potential to result in unmet patient needs. Findings include: 1. Patient #1 was a 57 year old female, admitted to the agency on 12/10/17, with a primary diagnosis of quadriplegia. Additional diagnoses included stage 2 pressure ulcers on each buttock, anxiety disorder, asthma, morbid obesity, and opioid dependence. She received SN, PT, OT, and MSW services. Her record, including the POC, for the certification period 12/12/17 to 2/07/18, was reviewed. Patient #1's record included an SOC comprehensive assessment dated 12/10/17. Patient needs identified on her assessment were not addressed in her POC. Examples include: a. Patient #1's SOC assessment included a diagnosis of dependence on supplemental oxygen. Her POC and medication list did not include her oxygen, with flow rate and frequency of use. b. Patient #1's SOC assessment included a Braden Scale, with a score of 13. The Braden Scale is a validated tool used by nurses to evaluate a patient's risk of developing a pressure	G 574		

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G 574	Continued From page 20 ulcer. The total score can range from 6 to 23 with a lower score indicating a higher risk. Patients scoring 18 or less are considered to be at risk of developing a pressure ulcer. Additionally, her SOC assessment documented 2 pressure ulcers. Her POC included orders for care of her existing pressure ulcers but did not include interventions to reduce the risk of developing additional pressure ulcers. During an interview on 8/16/18 at 2:20 PM, the branch Clinical Director confirmed Patient #1's POC did not include oxygen with flow rate and frequency of use, or interventions to address her risk of developing additional pressure ulcers. Patient #1's POC was not comprehensive to address all of her needs. 2. Patient #13 was an 84 year old male who was admitted for home health services on 10/12/17 with a primary diagnosis of venous insufficiency. Other diagnoses included leg ulcers, Insulin Dependent DM, kidney disease, and lymphedema (severe swelling) of his legs. He was discharged on 2/08/18. A comprehensive assessment visit was conducted by the RN on 10/12/17. The visit note stated Patient #13 was diabetic and was non-compliant with his diet. The note stated the patient performed blood glucose checks. The note did not state what Patient #13's blood sugar levels were but it said they were not "...WITHIN PATIENT SPECIFIC PARAMETERS." A question about "SANITATION ISSUES" stated CLUTTERED/SOILED AREA." Patient #13 was hospitalized from 12/01/17 to	G 574		

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G 574	Continued From page 21 12/04/17 for cellulitis of his legs. A resumption of care assessment visit was conducted by the RN on 12/07/17 at 10:35 AM. The assessment stated Patient #13 "CONTINUES TO HAVE [BLOOD] SUGAR OVER 250." The assessment also stated Patient #13 had "UNSAFE/UNSANITARY HOME CONDITIONS." Neither the initial POC for the certification period 10/12/17 to 12/10/17, nor POC for the certification period 12/11/17 to 2/08/18 for Patient #13 specifically addressed his unstable blood sugar levels or the unsafe and unsanitary conditions of his environment. The Clinical Director for the Meridian Branch reviewed Patient #13's record on 8/16/18 beginning at 10:00 AM. She stated the record did not contain specific POCs to address Patient #13's unstable blood sugar levels or the unsafe and unsanitary conditions of his environment. The ED was interviewed on 8/16/18 beginning at 4:05 PM. She stated Patient #13's house was not sanitary. She stated his environment could have contributed to his cellulitis which led to his hospitalization. Patient #13's POC did not address all pertinent diagnoses and items identified in his comprehensive assessments.	G 574		
G 576	All orders recorded in plan of care CFR(s): 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. This ELEMENT is not met as evidenced by:	G 576		

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G 576	Continued From page 22 Based on medical record review and staff interview, it was determined the agency failed to ensure all orders were recorded in the patient's POC for 1 of 17 patients (Patient #17) whose records were reviewed. This failure had the potential to interfere with the clarity of patients' POCs. Findings include: Patient #17 was a 93 year old male, admitted to the agency on 6/13/18, with a primary diagnosis of CHF. Additional diagnoses included cardiomyopathy, pleural effusion, and atrial fibrillation. He received SN, PT, and OT services. His record, including the POC, for the certification period 6/13/18 to 8/11/18, was reviewed. Patient #17's record included an SN visit note dated 6/29/18, signed by the RNCM. The note stated blood was drawn for laboratory tests. Patient #17's record did not include an order for laboratory tests to be completed on 6/29/18. During an interview on 8/16/18 at 2:05 PM, the ED reviewed Patient #17's record and confirmed it did not include an order for laboratory tests on 6/29/18. She stated the agency received the order electronically and did not record the order in Patient #17's POC. Patient #17's order for laboratory tests was not recorded in his POC.	G 576		
G 700	Skilled professional services CFR(s): 484.75 Condition of participation: Skilled professional services. Skilled professional services include skilled nursing services, physical therapy,	G 700		

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G 700	Continued From page 23 speech-language pathology services, and occupational therapy, as specified in §409.44 of this chapter, and physician and medical social work services as specified in §409.45 of this chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care. This CONDITION is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure skilled professional services assured ongoing interdisciplinary assessment, development of a POC in partnership with the patient, services provided as ordered by the physician, patient education, communication with physicians, and comprehensive and accurate MSW evaluations. This negatively impacted quality, coordination, and safety of patient care. Findings include: 1. Refer to G706 as it relates to the failure of the agency to ensure skilled professional staff performed ongoing interdisciplinary assessments. 2. Refer to G708 as it relates to the failure of the agency to ensure skilled professional staff developed a comprehensive POC in partnership with the patient. 3. Refer to G710 as it relates to the failure of the agency to ensure skilled services were provided as ordered by the physician on patients' POCs. 4. Refer to G714 as it relates to the failure of the agency to ensure skilled professionals provided patient education required to promote positive patient outcomes.	G 700		

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G 700	Continued From page 24 5. Refer to G718 as it relates to the failure of the agency to ensure skilled professionals notified physicians of changes in patients' conditions. 6. Refer to G726 as it relates to the failure of the agency to ensure care provided by the LPN was supervised by an RN. 7. Refer to G730 as it relates to the failure of the agency to ensure the MSW completed a comprehensive and accurate evaluation to identify the patient's needs and provided assistance in meeting those needs. The cumulative effects of these negative practices seriously impeded the ability of the agency to provide skilled professional services of adequate quality.	G 700		
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 and staff interview, it was determined the agency failed to ensure skilled professional staff performed ongoing interdisciplinary assessment of 2 of 17 patients (#12 and #13) whose records were reviewed. This failure resulted in an inability to identify problems and address patient needs. Findings include: 1. Patient #12 was a 79 year old female, admitted to the agency on 6/29/18, with a primary diagnosis of CHF. Additional diagnoses included COPD and morbid obesity. She received SN, PT, ST, and MSW services. Her record, including the	G 706		

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IDAHO HOME HEALTH & HOSPICE	222 SHOSHONE STREET EAST TWIN FALLS, ID 83301

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G 706	Continued From page 25 POC, for the certification period 6/29/18 to 8/27/18, was reviewed. Patient #12's primary diagnosis was CHF, a weakness of the heart that leads to a buildup of fluid in the lungs and other body tissues, often manifested by SOB, edema (swelling), and weight gain. Her POC stated "NOTIFY MD/SN FOR WEIGHT GAIN OF 3 LBS OVERNIGHT OR 5 LBS OVER ONE WEEK." Her record included an SN visit note, dated 7/13/18, signed by the RNCM. The note documented her weight as 267 pounds. Her record included an SN visit note, dated 7/17/18, signed by the RNCM. The note documented her weight as 271 pounds, a 4 pound weight gain in 4 days. Patient #12's record included a PT visit note, dated 7/20/18, signed by the PTA. The note stated, "PATIENT REPORTS THAT SHE IS NOT FEELING WELL TODAY, SOB, INCREASED EDEMA IN BILATERAL LOWER EXTREMITIES...PATIENT WAS UNABLE TO DEMONSTRATE PROGRESS TODAY DUE TO INCREASED EDEMA AND INCREASED SOB." The note stated Patient #12's RNCM was notified of her SOB and increased edema. Patient #12's record included a "Client Coordination Note Report," dated 7/22/18, signed by the RNCM. The note stated "72018 PT [patient] STATES NOT FEELING WELL DR OVERALL [sic] BY JUST TO CHECK REAL QUICK. WT [weight] UP A LITTLE WAS MORE SOB INCREASED EDEMA IN FEET PT STATES SHE TOOK DIURETIC PRN DOSE TODAY. HAD A REAL BUSY ACTIVE DAY YESTERDAY WITH FAMILY. PLANS TO REST AND ELEVATE FEET LUNGS WITH SLIGHT WHEEZING	G 706		

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G 706	Continued From page 26 OTHERWISE CLEAR. STATES IF WORSE TOMORROW WILL CONTACT ON CALL NURSE." Her record included an additional "Client Coordination Note Report," dated 8/15/18, that included the exact information above, followed by "DR [name] NURSE [name] NOTIFIED VIA PERSONAL CELL PHONE S [sic] STATES SHE WILL INFORM MD OF CURRENT CONDITION." Patient #12's record did not include an SN visit note dated 7/20/18. Her weight was not documented, to determine if she had additional weight gain since the 4 pound weight gain documented on 7/17/18. No additional SN visits were documented until 7/24/18. Patient #12's record included a PT visit note, dated 7/23/18, signed by the PTA. The note stated, "PATIENT CONTINUES TO NOT FEEL WELL AND DOES NOT DEMONSTRATE IMPROVEMENT." The note stated she had edema in both legs. Patient #12's record included an SN visit note, dated 7/24/18, signed by the LPN. The note stated her current weight was 47.33 kgs, which converts to 104.34 pounds. Patient #12's actual weight on 7/24/18 could not be determined. The cardiovascular assessment stated no problem was identified. The respiratory assessment stated abnormal breath sounds in all lobes. Patient #12's oxygen saturation level was not documented. The narrative section of the note documented edema in both legs. The note stated the LPN contacted the RNCM with an update on Patient #12. Patient #12's record included an ST visit note, dated 7/27/18, signed by the Speech Therapist.	G 706		

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G 706	Continued From page 27 The note documented communication with the RNCM, and stated "SPEECH THERAPIST CALLED TO TALK NURSE [sic] ABOUT PATIENTS WEIGHT, PATIENT WEIGHT IS REPORTED TO STILL BE UP 6 LBS. NURSE STATED THAT PATIENT COULD CALL DOCTOR TO MAKE A FOLLOW UP APPOINTMENT." No SN visit was documented to assess Patient #12's status. Patient #12's record included documentation of a transfer to the hospital on 7/27/18. The reason for her hospitalization stated "HEART FAILURE (FOR EXAMPLE, FLUID OVERLOAD.)" During an interview on 8/15/18 at 4:50 PM, the RNCM confirmed Patient #12 had a 4 pound weight gain from 7/13/18 to 7/17/18. He confirmed he received a call from the PTA on 7/20/18, to report increased SOB and edema. He stated the coordination note he wrote included errors and should have said he "drove by" to check on her. He stated he did not complete an assessment, did not take her vital signs or weight, and stated "I didn't touch her that day." The RNCM confirmed he added the information about contacting Patient #12's physician's office on 8/15/18, after learning the record was being reviewed by surveyors. He stated he did remember calling the physician's office. During the interview, the RNCM reviewed the SN visit note, dated 7/24/18, signed by the LPN, and confirmed Patient #12's weight was not correct. He stated he was on vacation at that time and did not receive an update from the LPN on Patient #12's status. The RNCM stated he did receive a call from the Speech Therapist on 7/27/18, while he was on vacation. He stated he did not realize	G 706		

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G 706	Continued From page 28 Patient #12 had gained 6 pounds. He confirmed he told the Speech Therapist to tell Patient #12 she could call the doctor for an appointment. He stated Patient #12 should have received an SN visit on 7/27/18, to assess her status due to her SOB, edema, and weight gain. The agency failed to ensure Patient #12 received an SN assessment due to changes in her condition. 2. Patient #13 was an 84 year old male who was admitted for home health services on 10/12/17 with a primary diagnosis of venous insufficiency. Other diagnoses included insulin dependent DM, lymphedema of his legs with chronic ulcers, and CHF. He was discharged on 2/08/18. A comprehensive assessment visit was conducted by the RN on 10/12/17. The visit note stated Patient #13 was diabetic and was non-compliant with his diet. The note stated the patient performed his blood glucose checks. The note did not state what Patient #13's blood sugar levels were but it said they were not "...WITHIN PATIENT SPECIFIC PARAMETERS." The assessment also stated Patient #13's home had "SANITATION ISSUES" and "CLUTTERED/SOILED AREA." Patient #13 was hospitalized from 12/01/17 to 12/04/17 for cellulitis of his legs. A resumption of care assessment visit was conducted by the RN on 12/07/17 at 10:35 AM. The assessment stated Patient #13 "CONTINUES TO HAVE [BLOOD] SUGAR OVER 250." The assessment also stated Patient #13 had "UNSAFE/UNSANITARY HOME CONDITIONS."	G 706		

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G 706	Continued From page 29 According to the American Diabetes Association web site, queried on 8/15/18, normal blood sugar readings for a diabetic person is between 70 and 130. Patient #13 was hospitalized from 12/01/17 to 12/04/17. Discharge documentation, dated 12/04/17 at 9:42 AM, listed his discharge diagnoses, including diabetic foot ulcer, uncontrolled insulin dependent diabetes mellitus, and diabetic peripheral neuropathy. While Patient #13 was on home health, he received nursing visits at least weekly. Patient #13's record contained 3 blood sugar readings, on 10/26/17, on 11/08/17, and on 1/12/18. All were above normal. The ED was interviewed on 8/16/18 beginning at 4:05 PM. She stated Patient #13's house was not sanitary. She stated his environment could have contributed to his cellulitis which led to his hospitalization. The Clinical Director for the Meridian Branch reviewed Patient #13's record on 8/16/18 beginning at 10:00 AM. She stated the record did not contain documentation that the nurse performed ongoing assessments of Patient #13's diabetes or of his environment. She stated the nurses did not update Patient #13's POC to address his diabetes and environmental hazards. The skilled nurse failed to assess Patient #12's diabetes and home environment.	G 706		
G 708	Development and evaluation of plan of care CFR(s): 484.75(b)(2)	G 708		

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G 708	Continued From page 30 Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s); This ELEMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure skilled professional staff developed a comprehensive POC in partnership with the patient for 1 of 17 patients (Patient #12) whose records were reviewed. This failure resulted in a POC that did not address all patient needs and had the potential to negatively affect patient care. Findings include: Patient #12 was a 79 year old female, admitted to the agency on 6/29/18, with a primary diagnosis of CHF. Additional diagnoses included COPD and morbid obesity. She received SN, PT, ST, and MSW services. Her record, including the POC, for the certification period 6/29/18 to 8/27/18, was reviewed. Patient #12's record included an SOC comprehensive assessment, dated 6/29/18, signed by the RNCM. The assessment stated she lived alone and did not receive assistance from persons other than the agency staff. The assessment stated Patient #12 required assistance of another person for bathing and putting on upper body clothing and was unable to put on lower body clothing by herself. Her POC did not include home health aide services. There was no documentation that Patient #12 was educated about or offered a home health aide to assist her with personal care. During an interview on 8/15/18 at 4:50 PM, the RNCM confirmed there was no documentation	G 708		

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G 708	Continued From page 31 Patient #12 was offered home health aide services to assist her with personal care. Patient #12 was not given information about all services offered by the agency to allow her to participate in the development of her POC.	G 708		
G 710	Provide services in the plan of care CFR(s): 484.75(b)(3) Providing services that are ordered by the physician as indicated in the plan of care; This ELEMENT is not met as evidenced by: Based on medical record review, staff interview, and observations it was determined the agency failed to ensure skilled services were provided as ordered by the physician on patients' POCs for 5 of 17 patients (#3, #6, #7, #12, and #15) whose records were reviewed. This failure resulted in patients not receiving skilled visits and care as ordered by the physician and had the potential to result in unmet patient needs. Findings include: 1. Patient #3 was a 56 year old female, admitted to the agency on 8/13/18, with a primary diagnosis of CHF. Additional diagnoses included morbid obesity, HTN, and DM type 2. Her referral information was reviewed, and her SOC comprehensive assessment completed by an RN was observed on 8/14/18. A visit was made to Patient #3's home on 8/13/18 at approximately 4:30 PM, with the RNCM, to observe her SOC assessment. The RNCM started the visit, reviewing rights and responsibilities and consent for services. Approximately 15 minutes into the visit, prior to signing consent for services, Patient #3 stated she had been to the physician's office earlier in	G 710		

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G 710	Continued From page 32 the day, was tired, and wanted to end the visit. The RNCM stated she would contact her the following day to arrange another visit. On 8/14/18 at approximately 10:00 AM, a progress note from Patient #3's physician appointment on 8/13/18, was provided. The progress note stated her oxygen saturation on room air was 87%. It included an order for oxygen 2 liters per minute, continuously. The Mayo Clinic website, accessed on 8/21/18, stated "Normal pulse oximeter readings usually range from 95 to 100 percent. Values under 90 percent are considered low." A visit was made to Patient #3's home on 8/14/18 at approximately 11:00 AM, with the RNCM, to observe her SOC assessment. Upon arrival to her home, it was noted Patient #3 was not using oxygen. An oxygen concentrator was present in the home, but it was not plugged in and no tubing was attached to it. The RNCM completed the visit without setting up the oxygen for use or educating Patient #3 to use her oxygen continuously as ordered by the physician. During an interview on 8/16/18 at 9:15 AM, the RN who completed Patient #3's SOC assessment confirmed she did not set up Patient #3's oxygen and instruct her in the use of oxygen. She stated she could not explain why she did not do that. Patient #3 was not instructed to use her oxygen continuously, as ordered by her physician. 2. Patient #12 was a 79 year old female, admitted to the agency on 6/29/18, with a primary diagnosis of CHF. Additional diagnoses included COPD and morbid obesity. She received SN, PT,	G 710		

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G 710	Continued From page 33 ST, and MSW services. Her record, including the POC, for the certification period 6/29/18 to 8/27/18, was reviewed. a. Patient #12's record documented she was admitted to the hospital on 7/27/18, for a CHF exacerbation. Her record included ROC orders, dated 8/01/18, signed by the RNCM. The orders included SN visits 3 times a week for 1 week, effective Sunday 7/29/18. Patient #12's record included a ROC comprehensive assessment, dated Wednesday 8/01/18, signed by the RNCM. Her record did not include additional SN visits during the week of 7/29/18 to 8/04/18. Patient #12's record documented she was admitted to the hospital on Sunday 8/05/18. During an interview on 8/16/18 at 11:45 AM, the ED reviewed Patient #12's record and confirmed 3 SN visits were ordered for the week of 7/29/18 to 8/04/18, and 1 SN visit was completed. Patient #12 did not receive SN visits as ordered on her POC. b. Patient #12 referral information from the hospital stated "continue speech therapy as an outpatient. If no improvement of voice in 1-2 weeks will follow up with ENT [ear, nose, and throat specialist] and Dr. [name] for vocal cord injections." Her record included an ST evaluation, dated 7/13/18, 2 weeks after her SOC. When questioned, the branch Clinical Director presented a physician's order that stated "SPEECH THERAPY UNABLE TO SEE PATIENT WITHIN 5 DAYS OF ADMISSION DUE TO SCHEDULE CONFLICT. SPEECH THERAPY	G 710		

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G 710	Continued From page 34 TO EVAL [EVALUATE]/DEVELOP POC WITH MD ON 7/13/18." The document stated the verbal order was received from the physician on 8/13/18, 2 weeks after her SOC. During an interview on 8/15/18 at 4:50 PM, the RNCM stated ST services were delayed because the agency's only Speech Therapist was on vacation. During an interview on 8/16/18 at 11:45 AM, the Administrator stated the agency had 1 Speech Therapist who worked 1 day a week and was shared between 2 branches. She stated the Speech Therapist was not on vacation but had a full schedule and could not complete Patient #12's evaluation prior to 7/13/18. She confirmed the verbal order for delay of ST services was received on 7/13/18, 2 weeks after the SOC. Patient #12 did not receive her ordered ST evaluation in a timely manner. 3. Patient #15 was an 80 year old female, admitted to the agency on 6/11/18, with a primary diagnosis of CHF. Additional diagnoses included Alzheimer's Disease and depression. She received SN services. Her record, including the POC, for the certification period 6/11/18 to 8/09/18, was reviewed. Patient #15's POC included an order to notify her physician for a weight gain of 2 pounds in one day or 5 pounds in 1 week. Her record included an SN visit note dated 6/15/18, signed by the RNCM, with a documented weight of 121.6 pounds. The next SN visit was documented on 6/18/18, signed by the RNCM. It documented her weight as 126 pounds. There was no	G 710		

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G 710	Continued From page 35 documentation her physician was notified of her weight gain of almost 5 pounds in 3 days. During an interview on 8/15/18 at 6:15 PM, the RNCM confirmed he did not notify Patient #15's physician of her weight gain. Patient #15's weight gain was not reported to her physician as ordered on her POC. 4. Patient #7 was a 74 year old male admitted to the agency on 7/28/18, with a a primary diagnosis of Parkinson's Disease. Additional diagnoses included essential HTN and chronic pain. He received SN, PT, OT, MSW, and aide services. His record, including the POC, for the certification period 7/28/18 to 9/25/18, was reviewed. Patient #7's POC included an order for SN visits 4 times a week for the week of 7/29/18. His record included an SN visit note, dated 8/01/18, signed by the LPN. Additionally, Patient #7's record included an SN visit note, dated 8/03/18, signed by the RN. No additional SN visits were documented during the week of 7/29/18 to 8/04/18. Patient #7 received 2 SN visits when 4 SN visits were ordered on his POC for the week of 7/29/18 to 8/04/18. The ED was interviewed on 8/15/18, beginning at 4:05 PM, and Patient #7's record was reviewed in her presence. She stated the EMR included 2 PRN visits in the frequency of visits for the week of 7/29/18 to 8/04/18. Patient #7's POC did not include documentation of PRN visits to be performed. She also stated the POC was sent to the physician for approval with no separation of	G 710		

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G 710	Continued From page 36 scheduled visits and PRN visits. She confirmed when reading Patient #7's POC, 4 SN visits were ordered and 2 SN visits were performed, for the week of 7/29/18 to 8/04/18. Patient #7 did not receive SN visits as ordered on the his POC. 5. Patient #6 was a 79 year old female admitted to the agency on 5/21/18, with a primary diagnosis of paroxysmal atrial fibrillation. Additional diagnoses included CHF and DM type II. She received SN and PT services. Her record, including the POC, for the certification period 7/20/18 to 9/17/18, was reviewed. Patient #6's POC included an order for SN visits 3 times a week for the week of 7/22/18. Her record included an SN visit note, dated 7/24/18, signed by the LPN. No additional SN visits were documented during the week of 7/22/18 to 7/28/18. Patient #6 received 1 SN visit when 3 SN visits were ordered on her POC for the week of 7/22/18 to 7/28/18. The ED was interviewed on 8/15/18, beginning at 4:05 PM, and Patient #6's record was reviewed in her presence. She stated the EMR included 2 PRN visits in the frequency of visits for the week of 7/22/18 to 7/28/18. Patient #6's POC did not include documentation of PRN visits to be performed. She also stated the POC was sent to the physician for approval with no separation of scheduled visits and PRN visits. She confirmed when reading Patient #6's POC, 3 SN visits were ordered and 1 SN visit was performed, for the week of 7/22/18 to 7/28/18.	G 710		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 37 Patient #6 did not receive SN visits as ordered on her POC.	G 710		
G 714	Patient and caregiver education CFR(s): 484.75(b)(5) Patient and caregiver education; This ELEMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure skilled professionals provided patient education required to promote positive patient outcomes for 1 of 17 patients (Patient #12) whose records were reviewed. This failure had the potential to result in negative patient outcomes. Findings include: Patient #12 was a 79 year old female, admitted to the agency on 6/29/18, with a primary diagnosis of CHF. Additional diagnoses included COPD and morbid obesity. She received SN, PT, ST, and MSW services. Her record, including the POC, for the certification period 6/29/18 to 8/27/18, was reviewed. The American College of Cardiology website, accessed on 8/20/18, included patient education entitled "Heart Failure: Checking Your Weight Daily." It stated "When you have heart failure, you need to watch for changes in your weight. A sudden weight gain can mean more fluid is building up in your body and your heart failure is getting worse." Additionally, it stated "Call your doctor if you notice a sudden weight gain. In general, call if you gain 3 pounds or more in 2 to 3 days." Patient #12's POC stated "NOTIFY MD/SN FOR	G 714		

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	137014	A. BUILDING _____ B. WING _____	08/16/2018

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G 714	Continued From page 38 WEIGHT GAIN OF 3 LBS OVERNIGHT OR 5 LBS OVER ONE WEEK." Her POC included orders for SN visits 1 time a week for 1 week, 2 times a week for 2 weeks, then 1 time a week for 6 weeks. Her record did not state she was educated to weigh herself daily and report a weight gain of 3 pounds overnight or 5 pounds in 1 week. During an interview on 8/15/18 at 4:50 PM, the RNCM stated Patient #12 was given a journal to record her weight. He confirmed there was no documentation Patient #12 was educated to weigh herself daily and report a weight gain of 3 pounds overnight or 5 pounds in 1 week to the RNCM or her physician. Patient #12 did not receive education to report weight gain related to her CHF.	G 714		
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 (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 skilled professionals notified physicians of changes in patients' conditions for 3 of 17 patients (#1, #4, and #12) whose records were reviewed. This failure had the potential for missed opportunities to update the POC to meet patients' needs. Findings include: The agency's policy "Coordination of Care, from Admit through Discharge" revised 1/01/18, stated	G 718		

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G 718	Continued From page 39 "At admission, throughout care, and at discharge, coordination of services is promoted through routine communication with the patient's physician: When changes occur in the patient's condition or response to treatment...When there is a need to change the patient's plan of care." 1. Patient #1 was a 57 year old female, admitted to the agency on 12/10/17, with a primary diagnosis of quadriplegia. Additional diagnoses included stage 2 pressure ulcers on each buttock, anxiety disorder, asthma, morbid obesity, and opioid dependence. She received SN, PT, OT, and MSW services. Her record, including the POC, for the certification period 12/12/17 to 2/07/18, was reviewed. Patient #1's POC included an order to notify her physician of pain rated greater than a 7 on a scale of 0 to 10 with 10 being the worst pain. Patient #1's record included a PT visit note, dated 12/15/17 beginning at 11:36 AM, signed by the Physical Therapist. The note documented "SEVERE PAIN IN LEFT LEG. UNKNOWN CAUSE. DESCRIBED AS A SPIRAL PAIN UP LEFT LEG." The note stated Patient #1 rated the pain as a 10. The note did not state Patient #1's physician was notified of her pain. During an interview on 8/16/18 at 2:20 PM, the branch Clinical Director reviewed Patient #1's record and confirmed there was no documentation her physician was notified of her pain. She confirmed the physician should have been notified of pain greater than 7. Patient #1's Physical Therapist failed to report her severe pain to her physician.	G 718		

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G 718	Continued From page 40 2. Patient #4 was an 81 year old male, admitted to the agency on 7/20/18, with a primary diagnosis of emphysema. Additional diagnoses included ASHD, insulin dependent DM, HTN, and morbid obesity. He received SN, PT, OT, ST, and aide services. His record, including the POC, for the certification period 7/20/18 to 9/17/18, was reviewed. Patient #4's medication list included Theophylline 125 mg to be taken daily, effective 7/27/18. Patient #4's record included an SN visit note, dated 7/30/18, signed by the RNCM. The note stated "NEW MEDICATION THEOPHYLLINE, PATIENT THINKS HE MAY HAVE HAD AN ADVERSE REACTIONS [sic] TO THIS MEDICATION SEVERAL YEARS AGO AND IS HESITANT TO TRY IT." Patient #4's record included an SN visit note, dated 8/01/18, signed by the RNCM. The note stated "NEW MEDICATION THEOPHYLLINE, PATIENT THINKS HE MAY HAVE HAD AN ADVERSE REACTIONS [sic] TO THIS MEDICATION SEVERAL YEARS AGO AND IS HESITANT TO TRY IT. PATIENT STILL HASN'T PICKED MED UP." Patient #4's record included an SN visit note, dated 8/07/18, signed by the RNCM. The note stated "NEW MEDICATION THEOPHYLLINE, PATIENT THINKS HE MAY HAVE HAD AN ADVERSE REACTIONS [sic] TO THIS MEDICATION SEVERAL YEARS AGO AND IS HESITANT TO TRY IT. PATIENT STILL HASN'T PICKED MED UP."	G 718		

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G 718	Continued From page 41 A visit was made to Patient #4's home on 8/14/18 at 2:00 PM, to observe an SN visit completed by the RNCM. During the visit, he showed the RNCM a bottle of Theophylline he had gotten from the pharmacy. He stated he was not taking the medication as he thought he had a reaction to it many years ago. He stated he wanted to speak with his physician before taking the Theophylline, but had not done so yet. There was no documentation in Patient #4's record that his physician was notified he was not taking the medication prescribed to him on 7/27/18 During an interview on 8/16/18 at 11:15 AM, the ED reviewed Patient #4's record and confirmed there was no documentation his physician was notified he was not taking Theophylline as ordered. She stated his physician should have been notified. Patient #4's RNCM failed to notify his physician he was not taking a medication as ordered. 3. Patient #12 was a 79 year old female, admitted to the agency on 6/29/18, with a primary diagnosis of CHF. Additional diagnoses included COPD and morbid obesity. She received SN, PT, ST, and MSW services. Her record, including the POC, for the certification period 6/29/18 to 8/27/18, was reviewed. The American College of Cardiology website, accessed on 8/20/18, included patient education entitled "Heart Failure: Checking Your Weight Daily." It stated "When you have heart failure, you need to watch for changes in your weight. A sudden weight gain can mean more fluid is	G 718		

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G 718	Continued From page 42 building up in your body and your heart failure is getting worse." Additionally, it stated "Call your doctor if you notice a sudden weight gain. In general, call if you gain 3 pounds or more in 2 to 3 days." Patient #12's POC stated "NOTIFY MD/SN FOR WEIGHT GAIN OF 3 LBS OVERNIGHT OR 5 LBS OVER ONE WEEK." Her record included an SN visit note, dated 7/13/18, signed by the RNCM. The note documented her weight as 267 pounds. Her record included an SN visit note, dated 7/17/18, signed by the RNCM. The note documented her weight as 271 pounds, a 4 pound weight gain in 4 days. There was no documentation her physician was notified of her weight gain. During an interview on 8/15/18 at 4:50 PM, the RNCM reviewed Patient #12's record and confirmed he did not inform her physician of her 4 pound weight gain in 4 days. Patient #12's RNCM failed to inform her physician of a change in her condition.	G 718		
G 726	Nursing services supervised by RN CFR(s): 484.75(c)(1) Nursing services are provided under the supervision of a registered nurse that meets the requirements of §484.115(k). This ELEMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure care provided by the LPN was supervised by an RN for 1 of 5 patients (Patient #12) who received LPN services and whose records were reviewed. This failure had the potential to impact	G 726		

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G 726	Continued From page 43 quality and coordination of patient care. Findings include: Patient #12 was a 79 year old female, admitted to the agency on 6/29/18, with a primary diagnosis of CHF. Additional diagnoses included COPD and morbid obesity. She received SN, PT, ST, and MSW services. Her record, including the POC, for the certification period 6/29/18 to 8/27/18, was reviewed. Patient #12's primary diagnosis was CHF, a weakness of the heart that leads to a buildup of fluid in the lungs and other body tissues, often manifested by SOB, edema (swelling), and weight gain. Her POC stated "NOTIFY MD/SN FOR WEIGHT GAIN OF 3 LBS OVERNIGHT OR 5 LBS OVER ONE WEEK." Her record included an SN visit note, dated 7/13/18, signed by the RNCM. The note documented her weight as 267 pounds. Her record included an SN visit note, dated 7/17/18, signed by the RNCM. The note documented her weight as 271 pounds, a 4 pound weight gain in 4 days. Patient #12's record included a PT visit note, dated 7/20/18, signed by the PTA. The note stated "PATIENT REPORTS THAT SHE IS NOT FEELING WELL TODAY, SOB, INCREASED EDEMA IN BILATERAL LOWER EXTREMITIES...PATIENT WAS UNABLE TO DEMONSTRATE PROGRESS TODAY DUE TO INCREASED EDEMA AND INCREASED SOB." The note stated Patient #12's RNCM was notified of her SOB and increased edema. Patient #12's record included a PT visit note, dated 7/23/18, signed by the PTA. The note stated "PATIENT CONTINUES TO NOT FEEL	G 726		

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G 726	Continued From page 44 WELL AND DOES NOT DEMONSTRATE IMPROVEMENT." The note stated she had edema in both legs. Patient #12's record included an SN visit note, dated 7/24/18, signed by the LPN. The note stated her current weight was 47.33 kgs, which converts to 104.34 pounds. Patient #12's actual weight on 7/24/18 could not be determined. The cardiovascular assessment stated no problem was identified. The respiratory assessment stated abnormal breath sounds in all lobes. Patient #12's oxygen saturation level was not documented. The narrative section of the note documented edema in both legs. The note stated the LPN contacted the RNCM with an update on Patient #12. The note did not document the RNCM's response to the update. It did not document communication with another RN. Patient #12's record included documentation of a transfer to the hospital on 7/27/18, prior to receiving another SN visit. The reason for her hospitalization stated "HEART FAILURE (FOR EXAMPLE, FLUID OVERLOAD.) During an interview on 8/15/18 at 4:50 PM, the RNCM confirmed Patient #12 had a 4 pound weight gain from 7/13/18 to 7/17/18. He reviewed the SN visit note, dated 7/24/18, signed by the LPN, and confirmed Patient #12's documented weight was not correct, and it could not be determined if she had gained additional weight. The RNCM stated he was on vacation at that time and did not receive a call from the LPN on 7/24/18. He stated he did not know if the LPN communicated with another RN, regarding Patient #12's status.	G 726		

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G 726	Continued From page 45 During an interview on 8/16/18 at 11:45 AM, the ED reviewed Patient #12's record and confirmed there was no documentation the LPN communicated with an RN on 7/24/18. She stated the LPN may have sent an email to the Clinical Director but was unable to provide evidence of an email. The agency failed to ensure care provided to Patient #12 by an LPN was supervised by an RN.	G 726		
G 730	Medical social services supervised by MSW CFR(s): 484.75(c)(3) Medical social services are provided under the supervision of a social worker that meets the requirements of §484.115(m). This ELEMENT is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the MSW completed a comprehensive and accurate evaluation to identify the patient's needs and provided assistance in meeting those needs for 1 of 4 patients (Patient #1) who received social services and whose records were reviewed. This resulted in a lack of assessment and care planning and missed opportunities to meet the patient's needs at home. Findings include: Patient #1 was a 57 year old female, admitted to the agency on 12/10/17, with a primary diagnosis of quadriplegia. Additional diagnoses included stage 2 pressure ulcers on each buttock, anxiety disorder, asthma, morbid obesity, and opioid dependence. She received SN, PT, OT, and MSW services. Her record, including the POC, for the certification period 12/12/17 to 2/07/18, was reviewed.	G 730		

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G 730	Continued From page 46 Patient #1's record included an SOC comprehensive assessment, dated 12/10/17, signed by the RN Case Manager. The assessment identified concerns, as follows: a. A nutrition screening stated "PATIENT IS AT A HIGH NUTRITIONAL RISK" due to pressure ulcers, consuming less than 2 servings of vegetables per day, taking more than 3 medications, and lack of funds to purchase appropriate food items. b. The assessment stated Patient #1 had personal care assistance through an agency prior to her hospitalization but the caregiver had not been there since her hospital discharge. It stated a neighbor who was developmentally delayed was able to provide some assistance. Additionally, the assessment stated, "INCONSISTENT SERVICE PROVISION RELATED TO CAREGIVER'S MENTAL CAPACITY." c. The assessment stated, "DETERMINE THE ABILITY AND WILLINGNESS OF NON-AGENCY CAREGIVERS...TO PROVIDE ASSISTANCE FOR ADL ASSISTANCE." "NON-AGENCY CAREGIVER(S) ARE NOT LIKELY TO PROVIDE ASSISTANCE OR IT IS UNCLEAR IF THEY WILL PROVIDE ASSISTANCE." Patient #1's record included a "Client Coordination Note Report" dated 12/10/17, signed by the RNCM. The note stated Patient #1 lived alone and stated, "SHE ALSO HAS A PAID CAREGIVER THAT USUALLY COMES IN MORNING ADN EVENING TO HELP HER GET UP OUT OF BED AND GO BACK TO BED. HER PAID CAREGIVERS HAVE NOT BEEN BACK	G 730		

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G 730	Continued From page 47 SINCE SHE HAS BEEN HOME FROM THE HOSPITAL AND SHE STATES SHE IS CALLING THEM TOMORROW TO GET THIS ARRANGED...PATIENTS HOME IS DIRTY AND CLUTTERED THERE IS GARBAGE LAYING AROUND AND ANIMAL FECES ON THE FLOOR...PATIENT STATES THAT SHE DID ARRANGE FOR MEALS ON WHEELS BUT THEY HAVE NOT SHOWN UP SINCE SHE HAS RETURNED FROM THE HOSPITAL AND SHE PLANS TO CALL THEM TOMORROW TO MAKE SURE THAT THEY GET SET UP. SOCIAL WORK ADDED ONTO ORDERS TODAY TO ASSIST PATIENT IN ANY FINANCIAL CONCERNS AND TO ARRANGE ANY COMMUNITY RESOURCES THAT SHE MAY NEED." Patient #1's record included an SN visit note, dated 12/13/18, signed by the RNCM. The note stated, "SHE HAS NOT BEEN EATING VERY MUCH SINCE SHE GOT HOME BECAUSE SHE DOES NOT HAVE GROCERIES." Additionally, it stated "PATIENT DID PREVIOUSLY HAVE AN IN-HOME CARE PROVIDER THAT WOULD COME IN THE MORNING AND IN THE EVENING TO ASSIST HER GETTING UP AND DOWN. HOWEVER THEY HAVE NOT BEEN BACK SINCE SHE HAS RETURNED FROM THE HOSPITAL AND SHE HAS NOT BEEN ABLE TO GET AHOLD OF THEM. A SOCIAL WORK ORDER WAS OBTAINED IN ORDER TO ASSIST THE PATIENT WITH BEING ABLE TO FIND ASSISTANCE FOR CARE SETTING UP MEALS ON WHEELS AND OTHER RESOURCES THE PATIENT MAY NEED. WILL CONTACT SOCIAL WORKER TO PROVIDE WITH REPORT AN [sic] UPDATE OF PATIENT SITUATION."	G 730		

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G 730	Continued From page 48 Patient #1's record included an OT evaluation, dated 12/13/17, signed by the Occupational Therapist. The note stated she needed assistance daily in the morning and evening, for completion of ADLs. Patient #1's record included an SN visit note, dated 12/19/17, signed by the RNCM. The note stated "PATIENT WOUND TO LEFT BUTTOCKS HAS INCREASED IN SIZE SECONDARY TO BEING LEFT IN URINE OVERNIGHT PATIENT STATES THAT HER UROSTOMY BAG LEAKED TWO DIFFERENT NIGHTS IN A ROW AND BECAUSE SHE IS ALONE AT NIGHT SHE SLEPT IN IT." Patient #1's record included a "Client Coordination Note Report" dated 12/19/17, signed by the RNCM. The note stated, "PATIENT STATES THAT SHE STILL HAS BEEN UNABLE TO GET A HOLD OF HER PREVIOUS CAREGIVER WHO WAS COMING IN THE MORNING IN THE EVENING TO HELP HER GET UP AND DRESSED AND BACK TO BED." Patient #1's record included an MSW visit note, dated 12/22/17, signed by the MSW. The note stated Patient #1 lived alone, had no regular caregiver, and her daughter, friends, and neighbors provided support. It stated her living area was cluttered and soiled. The MSW evaluation stated, "PRIOR TO HOSPITALIZATION, CLIENT HAD IN HOME SUPPORT TO ASSIST WITH HOUSEKEEPING AND MEALS." The note stated the MSW contacted the RNCM and discussed Patient #1's desire to go to a skilled nursing facility. The section of the assessment titled "Goals Not Met"	G 730		

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G 730	Continued From page 49 included "PATIENT TO BE PLACED IN APPROPRIATE LIVING SITUATION TO MEET IMMEDIATE SAFETY NEEDS," and "PATIENT DEMONSTRATES MAXIMUM UNDERSTANDING OF ASSESSED HIGH RISK SITUATION AND EMERGENCY PLANS. Both stated "NOT APPLICABLE TO CURRENT VISIT." The assessment did not address Patient #1's need for a caregiver or Meals on Wheels. It stated no further visits were planned. Patient #1's record included an SN visit note, dated 12/27/17, signed by the RNCM. It stated "PATIENT CONTINUES TO STAY UP IN HER CHAIR OVERNIGHT AND HAD HAD HER UROSTOMY LEAK MULTIPLE TIMES AND HAS SLEPT IN IT THIS LEADING TO MORE BREAKDOWN OF HER SKIN ON HER BOTTOM...I HAVE NOTIFIED THE PHYSICIAN THAT SHE REALLY NEEDS ASSISTANCE IN HOME..." Patient #1's record included an SN visit note, dated 12/29/17, signed by the RNCM. It stated "I ASK [sic] THE PATIENT IF HER DAUGHTER WAS ABLE TO BE OF ASSISTANCE SHE SAID NO SHE'S TOO BUSY. I ASKED HER IF SHE HAD HAD ANY LUCK TRYING TO GET A CARE PROVIDER TO HELP HER IN HER HOME BUT SHE STATED THAT HER CARE PROVIDER THAT SHE HAD PREVIOUSLY WILL NOT ANSWER HER CALLS OR RESPOND TO HER TEXT...I ASK THE PATIENT IF SHE HAD FINANCIAL RESOURCES IN ORDER TO PAY FOR AN IN-HOME CARE PROVIDER AS INSURANCE TYPICALLY DOES NOT PAY FOR THIS SHE STATED THAT SHE DOES NOT HAVE ANY EXTRA FINANCIAL RESOURCES AND DOESN'T HAVE ANY FAMILY THAT CAN	G 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137014	A. BUILDING _____ B. WING _____	08/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO HOME HEALTH & HOSPICE	222 SHOSHONE STREET EAST TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 730	Continued From page 50 ASSIST HER." During a telephone interview on 8/16/18 at 2:20 PM, the MSW stated she needed to review her notes on Patient #1 as she did not remember the visit. After reviewing her notes, she stated she had written down that Patient #1 was receiving 60 hours of caregiver assistance a week and her daughter was assisting with groceries. She stated she did not have notes related to setting up Meals on Wheels, or placement in an SNF. She confirmed she made 1 visit to Patient #1 and did not provide follow up services. The agency failed to ensure Patient #1's needs related to assistance in the home, assistance with acquiring meals, and placement in a safe environment were met by the MSW.	G 730		