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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November 23, 2018

Michael Hull, Administrator
Loving Care And More
PO Box 119
Silverton, ID 83867

RE: Loving Care And More, Provider #137074

Dear Mr. Hull:

This is to advise you of the findings of the Medicare/Licensure survey at Loving Care And More, which was concluded on November 15, 2018.

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

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

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

After you have completed your Plan of Correction, return the original to this office by **December 3, 2018**, and keep a copy for your records.

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

Sincerely,

Dennis Kelly RN

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 |
|---|---|---|---|
| | 137074 | A. BUILDING _____ B. WING _____ | 11/15/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LOVING CARE AND MORE | 104 WINDRIVER ROAD SILVERTON, ID 83867 |

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| G 000 | INITIAL COMMENTS<br><br>The following deficiencies were cited during the recertification survey at your agency. Surveyors conducting the visit were:<br><br>Gary Guiles, RN, HFS, Team Leader<br>Teresa Hamblin, RN, MS, HFS<br>Weslianne Lewis, RN, HFS<br><br>The following acronyms were used in this report.<br><br>ALF - Assisted Living Facility<br>iu - international units<br>MAR - Medication Adminstration Record<br>mEq - milliequivalent<br>mg - milligram<br>OT - Occupational Therapy<br>PO - By mouth<br>POC - Plan of care<br>PT - Physical Therapy<br>RN - Registered Nurse<br>Rt - Right<br>SN - Skilled Nursing<br>ST - Speech Therapy | G 000 | RECEIVED<br>DEC 07 2018<br>FACILITY STANDARDS | |
| G 536 | A review of all current medications<br>CFR(s): 484.55(c)(5)<br><br>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.<br>This ELEMENT is not met as evidenced by:<br>Based on medical record review, policy review, observation in the home, staff interview, and caregiver interview, it was determined the agency failed to ensure a comprehensive drug regime | G 536 | Administrator reviewed with all staff Policy C-700 Medication Profile. I combined this with policy C-709 Medication Reconciliation to make it less confusing.<br>The patients MAR has been corrected to reflect the correct medications, OTC, medications herbal remedies vitamins, or anything else the patient was taking, along with the correct dose, and frequency. The nurses and therapists have been in-serviced on the proper time frames to reconcile medications and to update the MAR as appropriate. We will audit 5 charts a month to make sure we have all medications, OTC, herbal remedies, vitamins or anything else that a patient maybe taking listed on the MAR, this will be done by the administrator, and administrator assistant | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] R.N. | PRESIDENT | 11/30/18 |

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 536 | Continued From page 1<br>review was completed for 2 of 8 patients (#4 and #6) whose records were reviewed. This had the potential to result in adverse events, duplicative drug therapy, or negative drug interactions. Findings include:<br><br>An undated agency policy C-705 "MEDICATION MANAGEMENT" stated "Comprehensive patient assessment performed at start of care and other defined points in time include review of all medications the patient is taking (prescribed, samples, over the counter, herbal remedies, PRN medications) and records this in the patient record."<br><br>Medications were not not comprehensively assessed. Examples include:<br><br>1. Patient #6 was a 76 year old female admitted to the agency on 1/04/16, with a primary diagnosis of right sided hemiplegia related to cerebrovascular disease. Additional diagnoses included dysphasia, pressure ulcer, Type 2 diabetes mellitus, and epileptic seizures. She received PT, OT, ST, SN, and aide services. Her record, including the POC, for certification period that began 10/20/18 was reviewed.<br><br>During a visit to Patient #6's home on 11/14/18 between 3:08 PM and 5:15 PM, the surveyor reviewed medications with Patient #6's daughter, the individual who identified herself as the person who managed Patient #6's medications. Medications were compared to a current medication list (Medication Administration Record [MAR]) provided by the Clinical Director prior to the home visit.<br><br>Discrepancies were noted between the MAR and | G 536 | This audit will continue until we achieve 95% compliance. We also are developing a magnet for our patients asking them to alert us of any changes to their medications including OTC meds.<br>We also in serviced staff on policy C-500 Patient transfer and discharge policy. To ensure that all the patients medications or other care needs are being relayed to the correct person to ensure no laps in care.<br>Administrator will be responsible to make sure this audit is complete we will audit 5 charts a month until we hit 95% compliance. | |

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| G 536 | Continued From page 2<br>the medications in the home. Examples include:<br><br>- The MAR documented Potassium 30 mEq PO 1 time daily. The medication bottle had a different dose: 20 mEq PO 1 time daily. The daughter stated Patient #6 took 1 dose of 20 mEq daily.<br><br>- The MAR documented Magnesium 250 mg PO 2 tabs in am/ 1 tab at 1 pm. The daughter stated Patient #6 took 1 tablet in the morning and 1 tablet at night. This is a total 2 tabs daily rather than 3 tabs as stated on the MAR.<br><br>- The MAR documented Tylenol 650 mg PO every 6 hours as needed for pain. Patient #6 had Tylenol 500 mg in the home. The daughter stated Patient #6 took 1 500 mg tab in the morning and 1 500 mg tab in the evening, and 1 500 mg tab during the day on an as-needed basis.<br><br>- The MAR documented Vitamin D-3 5000 iu 1 tab daily. The dosage of 2000 iu was listed on the medication bottle . The daughter stated Patient #6 took 1 tab of Vitamin D-3 2000 iu daily.<br><br>- The daughter stated Patient #6 took Glimepiride 2 mg 1 tab by mouth in the mornings. This medication was not on the MAR.<br><br>- The daughter stated Patient #6 took Cranberry 300 mg 1 in am and 1 in evening. This supplement was not on the MAR.<br><br>- Mupirocin ointment 2 percent included a label for Patient #6 with directions to apply to shin and toe area. This ointment was not on the MAR.<br><br>- The home health aide, in the presence of | G 536 | | |

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| G 536 | Continued From page 3<br>Patient #6's daughter, retrieved Phytoplex Antifungal Powder from another area in Patient #6's home. The aide stated the powder was applied under Patient #6's breasts and in her underwear area. This medicated powder was not on the MAR.<br><br>- The home health aide, in the presence of Patient #6's daughter, retrieved a Moisture Barrier Antifungal Cream from another area in Patient #6's home. This medicated cream was not on the MAR.<br><br>Patient #6's RN Case Manager was out of the office and unavailable for interview.<br><br>The Clinical Director was interviewed on 11/15/18 at 9:10 AM. He confirmed reviewed the record and confirmed the medication discrepancies.<br><br>Patient #6's medications were not comprehensively reviewed and kept current.<br><br>2. Patient #4 was a 92 year old female admitted to the agency on 3/27/18, with a primary diagnosis of weakness. Additional diagnoses included dementia, chronic atrial fibrillation and hypertension. She resided in an ALF and received PT, OT, and ST services. Her record, including the POC, for certification period 3/27/18 to 5/25/18, was reviewed.<br><br>A "Physician Notification & Request," dated 5/01/18, notified Patient #4's physician that Patient #4 was discontinued from home health services and goals were met. It also informed the physician the ALF reported Patient #4 was on an antibiotic for a urinary tract infection. The specific medication was not listed in the communication to | G 536 | | |

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| G 536 | Continued From page 4<br>the physician or in Patient #4's medication record. There was no evidence the antibiotic was evaluated to determine any potential drug interactions or potential adverse effects.<br><br>The Clinical Director was interviewed on 11/15/18 at 9:45 AM. He reviewed Patient #4's record and confirmed the antibiotic was not specifically identified or reviewed.<br><br>Patient #4's new medication (antibiotic) was not reviewed for potential adverse effects or reactions. | G 536 | | |
| G 642 | Program scope<br>CFR(s): 484.65(a)(1),(2)<br><br>Program scope.<br>(1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care.<br>(2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations.<br>This STANDARD is not met as evidenced by:<br>Based on staff interview and review of policies and medical records, it was determined the agency failed to ensure adverse patient events were measured, analyzed, and tracked. This directly affected 1 of 1 patient (Patient #8), who had an adverse patient event, and had the potential to affect the care of all patients at the agency. This resulted in a lack of information the agency could use to evaluate its processes.<br>Findings include: | G 642 | We have developed a new adverse event tracking form and we have in-services all staff on the correct way to complete, what events need to be reported. We have integrated that into our QAPI program for continued evaluation. The adverse events will be tracked, analyzed for further intervention or training and considered for a possible Performance Improvement Plan under our QAPI program. The members of our QAF program which include an aide, a physical therapist and a nurse will review the results and make recommendations. The QAPI team will meet at a minimu once a quarter to review the findings. This form will be presented to the agencies Advisory Board for inclusion in our QAPI program The administrator will be responsible f implementing this correction plan once it's approved by th Advisory Board | |

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| G 642 | Continued From page 5<br><br>Patient #8's medical record contained documentation of a fall on 11/06/18. The fall resulted in bruising. An occurrence report for analyzing and tracking the fall was not present at the agency.<br><br>The Clinical Director was interviewed on 11/15/18 beginning at 1:30 PM. He stated the agency did not complete occurrence reports when an adverse patient event occurred. He stated a policy that specified how adverse patient events would be documented, analyzed, and tracked had not been developed. He stated the agency did not have a system to analyze and track adverse patient events.<br><br>The agency failed to develop a system to analyze and track adverse patient events. | G 642 | | |
| G 798 | Home health aide assignments and duties CFR(s): 484.80(g)(1)<br><br>Standard: Home health aide assignments and duties.<br>Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist).<br>This STANDARD is not met as evidenced by:<br>Based on record review, policy review, observation, and staff interview, it was determined the RN did not update a written aide care plan to reflect the needs of the patient and provide verbal instructions to an aide for 1 of 1 | G 798 | The home health administrator reviewed polices C-751 and C220, with all Registered Nurses and Therapists who assign home health aides, as well as an in service for all home health aides. The in service covered the correct way to complete a HHA care plan, as well as what duties could be assigned to a HHA, and the supervision of HHA. The correct way to update a care plan was also included The administrator also educated the HHA on the correct procedure to address discrepancies in the patients care plan. Staff was also educated on the customization of care planning to include care being provided by the family or other caregivers. The home health administrator will be responsible to audit 3 charts a month to ensure compliance until 95% | |

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| G 798 | Continued From page 6<br>patient (Patient #6) whose aide care was observed in the home and whose record was reviewed. This resulted in an outdated aide care plan and had the potential to interfere with quality and coordination of patient care. Findings include:<br><br>Agency policy C-780, "HOME HEALTH AIDE: ASSIGNEMENT" [sic], dated 2017, stated:<br><br>- "The initial assessment for need of home health aide services shall be determined by the authorized nurse/therapist. The assignment of tasks will be identified in the home health aide care plan/Assignment Sheet."<br><br>- "All changes in the assignment will be communicated to the Home Health Aide and will be documented on a new Care Plan."<br><br>An agency policy C-751, "HOME HEALTH AIDE CARE PLAN," dated 2017, stated:<br><br>- "A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse or Therapist."<br><br>- "The Home Health Aide cannot be responsible for performing any procedure that is not assigned to him/her in writing by the Registered Nurse/Therapist..."<br><br>Agency policy C-220, "HOME HEALTH AIDE SERVICES, dated 2018, stated:<br><br>- A specific care plan is developed documenting the Aide services to be provided." | G 798 | compliance is achieved. | |

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| G 798 | Continued From page 7<br>- "Delegated nursing tasks performed by home health aides must be properly delegated and documented according to specific State/Federal and agency policies."<br><br>Patient #6 was a 76 year old female admitted to the agency on 1/04/16, with a primary diagnosis of right sided hemiplegia related to cerebrovascular disease. Additional diagnoses included dysphasia, pressure ulcer, Type 2 diabetes mellitus, and epileptic seizures. She received PT, OT, ST, SN, and aide services. Her record, including the POC for certification period that began 10/20/18 was reviewed.<br><br>During a home visit on 11/14/18 between 3:08 PM and 5:15 PM, a surveyor observed an aide providing care to Patient #6 .<br><br>The aide was observed to provide services not included on the written aide plan of care. Examples include:<br><br>- She placed a heated rice pack under Patient #6's right forearm.<br><br>- She placed a heated rice pack to Patient #6's shin.<br><br>- She straightened/stretched the digits of Patient #6's right hand.<br><br>- She engaged Patient #6 in word exercises, asking questions, such as "list me five things you would shout," "name four kinds of birds," "name me something in the sky that starts with s," "name a book that starts with s," and "state an excuse for being late." | G 798 | | |

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| G 798 | Continued From page 8<br>- She stated she usually did leg exercises but did not do them during the observed visit because Patient #6 complained of soreness.<br><br>Hair, skin, and foot care were included in the written aide plan of care for Patient #6. They were not provided during the obsrved visit.<br><br>During the home visit, the aide stated the Speech Therapist taught her to ask the word searching questions and the Occupational Therapist instructed her to offer Patient #6 the warm pack and to straighten the fingers/thumb of her right hand. She stated "It helps with toning." She stated the Occupational Therapist also had her assist Patient #6 with leg exercises "as tolerated." She explained she did not do the leg exercises during the visit because Patient #6 complained of soreness. These instructions were not included in the written aide care plan.<br><br>During a second interview on 11/15/18 at 8:00 am, the aide explained she had been trained by the Occupational Therapist and Speech Therapist to do exercises. She confirmed the OT and ST exercises were not included on the written aide care plan. She stated Patient #6 had a morning caregiver who often addressed hygiene needs. She stated she addressed Patient #6's hygiene needs depending on whether the morning caregiver attended to those needs and whether there had been any incontinent episodes since the morning caregiver left for the day. The aide stated she did not do nail care at all because the daughter or nurse did it.<br><br>Patient #6's RN Case Manager was not available for interview during the survey. | G 798 | | |

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| G 798 | Continued From page 9<br>The Clinical Director was interviewed on 11/15/18 at 9:10 AM. He reviewed Patient #6's record and confirmed the written aide care plan did not reflect the care being provided or current needs of the patient. He stated, "Therapy exercises should be marked."<br><br>The written aide care plan for Patient #6 was incomplete. It did not include therapy exercise or guidance as to when it was appropriate to omit hygiene care. | G 798 | | |
| G 800 | Services provided by HH aide<br>CFR(s): 484.80(g)(2)<br><br>A home health aide provides services that are:<br>(i) Ordered by the physician;<br>(ii) Included in the plan of care;<br>(iii) Permitted to be performed under state law; and<br>(iv) Consistent with the home health aide training.<br>This ELEMENT is not met as evidenced by:<br>Based on record review, policy review, observation, and staff interview, it was determined the agency failed to ensure the home health aide provided services in accordance with the written aide care plan for 2 of 2 patients (#6 and #8) who received aide services and whose records were reviewed. This resulted in care provided that was not included in the aide care plan, and care omitted that was included in the aide care plan. This had the potential to interfere with quality, consistency, and coordination of patient care and result in unmet patient needs.<br>Findings include:<br><br>An agency policy C-751, "HOME HEALTH AIDE CARE PLAN," dated 2017, stated "A complete and appropriate Care Plan, identifying duties to | G 800 | We in serviced all nurses/therapists who prepare HHA care plans on policy C-751 and the HHA on policy C220. These in services covered the care plan development for the patient and aide as well as what could be included on the aide care plan.<br>We also re-educated the nurses and therapists on the correct way to handle a situation that develops where an aide is asked to do something that isn't on the ca plan, or if the aide notices something that he or she thinks needs to be addressed that isn't on the care plan.<br>We also educated all of our schedulers on the importance notifying the case manager when a missed visit occurs or going to occur so we can notify the patient and make sure their care isn't compromised. The administrator will be responsible to audit 5 charts a month until 90% compliance is achieved. | |

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| G 800 | Continued From page 10<br>be performed by the Home Health Aide, shall be developed by a Registered Nurse or Therapist. All home health aide staff will follow the identified plan."<br><br>Agency policy C-220, "HOME HEALTH AIDE SERVICES, dated 2018, stated "The Aide will follow the care plan and will not initiate new services or discontinue services without contacting the supervising Nurse/therapist."<br><br>1. Patient #6 was a 76 year old female admitted to the agency on 1/04/16, with a primary diagnosis of right sided hemiplegia related to cerebrovascular disease. Additional diagnoses included dysphasia, pressure ulcer, Type 2 diabetes mellitus, and epileptic seizures. She received PT, OT, ST, SN, and aide services. Her record, including the POC for certification period that began 10/20/18 was reviewed.<br><br>a. Aide documentation for visits on the following 10 dates were reviewed: 10/22/18, 10/23/18, 10/24/18, 10/25/18, 10/26/18, 11/05/18, 11/06/18, 11/07/18, 11/08/18, and 11/09/18.<br><br>Patient #6's aide care plan included hair care, skin care, and foot care every visit and nail care weekly. There was no documentation these tasks had been completed during these 10 visits.<br><br>b. During a home visit on 11/14/18 between 3:08 PM and 5:15 PM, a surveyor observed an aide providing care to Patient #6 .<br><br>The aide was observed to provide services not included on the written aide plan of care. Examples include: | G 800 | | |

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|---|---|---|---|
| | 137074 | A. BUILDING _____ B. WING _____ | 11/15/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LOVING CARE AND MORE | 104 WINDRIVER ROAD SILVERTON, ID 83867 |

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| G 800 | Continued From page 11<br>- She placed a heated rice pack under Patient #6's right forearm.<br><br>- She placed a heated rice pack to Patient #6's shin.<br><br>- She straightened/stretched the digits of Patient #6's right hand.<br><br>- She engaged Patient #6 in word exercises, asking questions, such as "list me five things you would shout," "name four kinds of birds," "name me something in the sky that starts with s," "name a book that starts with s, and "state an excuse for being late."<br><br>- She stated she usually did leg exercises but did not do them during the visit because Patient #6 complained of soreness. Leg exercises were not included in the aide care plan.<br><br>Hair, skin, and foot care were included in the written aide plan of care for Patient #6. They were not observed to be provided.<br><br>During the home visit, the aide stated the Speech Therapist taught her to ask the word searching questions and the Occupational Therapist instructed her to offer Patient #6 the warm pack and to straighten the fingers/thumb of her right hand. She stated "It helps with toning." She stated the Occupational Therapist also had her assist Patient #6 with leg exercises "as tolerated." She explained she did not do the leg exercises during the visit because Patient #6 complained of soreness. These instructions were not included in the written aide care plan.<br><br>During a second interview on 11/15/18 at 8:00 | G 800 | | |

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| LOVING CARE AND MORE | 104 WINDRIVER ROAD SILVERTON, ID 83867 |

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| G 800 | Continued From page 12<br>AM, the aide explained she had been trained by the Occupational Therapist and Speech Therapist to do exercises. She confirmed the OT and ST exercises were not included on the written aide care plan. She stated Patient #6 had a morning caregiver who often addressed hygiene needs. She stated she addressed Patient #6's hygiene needs depending on whether the morning caregiver attended to those needs and whether there had been any incontinent episodes since the morning caregiver left for the day. The aide stated she did not do nail care at all because the daughter or nurse did it.<br><br>Patient #6's RN Case Manager was not available for interview during the survey.<br><br>The Clinical Director was interviewed on 11/15/18 at 9:10 AM. He reviewed Patient #6's record and confirmed the care observed by the surveyor was not consistent with the written aide care plan.<br><br>Aide care provided to Patient #6 was not consistent with the written plan of care.<br><br>2. Patient #8 was an 82 year old female admitted to the agency on 9/25/18 with diagnoses of weakness, unstable gait, and care for a status post fracture of the right hip. She received SN, PT, OT, ST, and aide services. Her record, including the POC, for the certification period 9/25/18 to 11/23/18, was reviewed.<br><br>Patient #8's record included a POC dated 9/25/18, signed by the physician. The POC stated the frequency of aide visits as 1 visit for the first week then 2 visits per week for 4 weeks starting 9/27/18. | G 800 | | |

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| G 800 | Continued From page 13<br>Patient #8's record included only one aide visit during the weeks of 10/14/18 to 10/20/18 and 10/22/18 to 10/25/18.<br><br>During an interview on 11/15/18 at 2:30 PM, the Clinical Manager reviewed Patient #8's record and confirmed there was documentation for one aide visit during the weeks of 10/14/18 to 10/20/18 and 10/22/18 to 10/25/18. He confirmed that the aide was not completing visits as ordered on the POC.<br><br>Aide care provided to Patient #8 was not consistent with the written plan of care. | G 800 | | |
| G 804 | Aides are members of interdisciplinary team<br>CFR(s): 484.80(g)(4)<br><br>Home health aides must be members of the interdisciplinary team, must report changes in the patient's condition to a registered nurse or other appropriate skilled professional, and must complete appropriate records in compliance with the HHA's policies and procedures.<br>This ELEMENT is not met as evidenced by:<br>Based on observation, policy review, record review, and staff interview, it was determined the agency failed to ensure aides documented reports to the RN Case Manager in the clinical record for 1 of 1 patient (Patient #6) whose aide care was observed and whose record was reviewed. This resulted in a lack of clarity as to actual coordination of patient care. It had the potential to result in unmet patient needs.<br>Findings include:<br><br>Agency policy C-680, "CLINICAL DOCUMENTATION," dated 2017, stated "Telephone or other communication with patients, | G 804 | I in serviced all staff on policy C-680 and the importance of interdisciplinary communication and coordination of care. All communication regarding patient care will be documented in the patients chart. Both the individuals concern as well as the response will be documented. We have both an EHR form titled "Care Coordination Note: Form# 3577/2 or a paper form that is preprinted in the patients chart either way is acceptable. We also educated the staff to include the nurse manager in these communications in case of the absence of the case manager. We also addressed the correct way to use our encrypted email system for communication and revised policy C-680 to include the use of email. Home Health administrator will be responsible to audit 5 charts a month until 100% compliance is reached. | |

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| G 804 | Continued From page 14<br>physicians, families, or other members of the health care team will be documented in clinical progress notes or other interagency communication form.<br><br>Communication was not documented. An example includes:<br><br>Patient #6 was a 76 year old female admitted to the agency on 1/04/16, with a primary diagnosis of right sided hemiplegia related to cerebrovascular disease. Additional diagnoses included dysphasia, pressure ulcer, Type 2 diabetes mellitus, and epileptic seizures. She received PT, OT, ST, SN, and aide services. Her record, including the POC for certification period that began 10/20/18 was reviewed.<br><br>During a home visit on 11/14/18 between 3:08 PM and 5:15 PM, a surveyor observed an aide providing care to Patient #6. During the home visit, the aide stated she was going to email the RN Case Manager about pain Patient #6 reported and an "aspirin" was provided upon Patient #6's request. (The aide was observed providing Tylenol, not aspirin, to the paitient). She paused during the visit, typed on her phone, and said she emailed the RN Case Manager the update.<br><br>The "HOME HEALTH AIDE WEEKLY VISIT RECORD," documented the following note: "11/14/18. Left and Rt legs swollen. Rt shin sore. Rt hip sore 3/10 took an aspirin." There was no documentation the RN Case Manager was notified.<br><br>Patient #6's aide was interviewed on 11/15/18 at 8:00 AM. When asked how she generally communicated with the RN Case Manager, she | G 804 | | |

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| G 804 | Continued From page 15<br>stated she emailed her regularly and once a week she had face to face communication during a weekly meeting. She stated she emailed the RN Case Manager on 11/14/18 during the visit with Patient #6. When asked if the email communication was included in patient records, she replied "no."<br><br>Patient #6's RN Case Manager was not available for interview as she was not working during the survey week. She would not have received or responded to the email as she was not working.<br><br>The Clinical Director was interviewed on 11/15/18 at 9:10 AM. He stated it was his expectation that aides and clinical staff document coordination, whether by email and phone, in medical records. He confirmed the RN Case Manager was out of the office for the week and would not have been available to respond to email communcation. | G 804 | | |

Bureau of Facility Standards

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|---|---|---|---|
| | OAS001330 | A. BUILDING: _____ B. WING _____ | 11/15/2018 |

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| N 000 | INITIAL COMMENTS<br><br>The following deficiencies were cited during the state licensure survey at your agency. Surveyors conducting the visit were:<br><br>Gary Guiles, RN, HFS, Team Leader<br>Teresa Hamblin, RN, MS, HFS<br>Weslianne Lewis, RN, BSN, HFS<br><br>The following acronyms were used in this report:<br><br>CNA - Certified Nursing Assistant<br>CPR - Cardiopulmonary Resuscitation<br>LPN - Licensed Practical Nurse<br>PT - Physical Therapist | N 000 | RECEIVED<br>DEC 07 2018<br>FACILITY STANDARDS | |
| N 051 | 03.07021. ADMINISTRATOR<br><br>N051 03. Responsibilities. The administrator, or his designee, shall assume responsibility for:<br><br>e. Personnel records of staff working directly with patients shall include: qualifications, licensure or certification when indicated, orientation to home health, the agency and its policies; performance evaluation, and documentation of attendance or participation in staff development, in-service, or continuing education; documentation of a current CPR certificate; and other safety measures mandated by state/federal rules or regulations.<br><br>This Rule is not met as evidenced by:<br>Based on review of personnel records, agency policy, and staff interview, it was determined the | N 051 | All staff are now current on their CPR certifications and we have implemented a tracking system to ensure compliance. All past due performance reviews will be caught up by 12/14/18 and will be maintained current by the nurse manager or the administrator. The home health administrator will be responsible to ensure compliance. | |

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

RN. PRESIDENT 11/30/18

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| N 051 | Continued From page 1<br>agency failed to ensure personnel records included current CPR certificates for 3 of 11 staff (Staff B, D, and K) and performance evaluations for 2 of 11 staff (Staff E and F), who provided direct patient care and whose personnel files were reviewed. This had the potential for care being provided by unqualified personnel. Findings include:<br><br>1. Agency personnel records were reviewed on 11/13/18 at 2:00 PM.<br><br>a. Current CPR certification was not included in the personnel record for Staff B, an LPN.<br>b. Current CPR certification was not included in the personnel record for Staff D, a CNA.<br>c. Current CPR certification was not included in the personnel record for Staff B, a PT.<br><br>2. An agency administrative document "Competency Evaluation of Home Care Staff," dated 2017, stated the agency will conduct annual performance evaluations of all employees.<br><br>Agency personnel records were reviewed on 11/13/18 at 2:00 PM.<br><br>Documentation of 2017 and 2018 annual performance evaluations for Staff D and E, both CNAs, were not included in their personnel files.<br><br>During an interview on 11/15/18 at 2:30 PM, the Clinical Manager reviewed the agency personnel files and confirmed there was no documentation of current CPR certification for Staff B, D, and K. When asked if the agency had documentation of annual performance evaluations for Staff D and E, he stated the 2017 and 2018 reviews were done at the same time annual raises were given but they were not documented. | N 051 | | |

Bureau of Facility Standards

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| N 051 | Continued From page 2<br><br>The agency failed to ensure personnel records included current CPR certificates and performance evaluations for personnel who provide direct patient care. | N 051 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| E 000 | Initial Comments<br><br>The Medicare recertification survey of your agency, including Emergency Preparedness, was conducted on 11/13/18 to 11/15/18 and was found in substantial compliance for the regulations found in Appendix Z of the State Operations Manual. Surveyors conducting the recertification survey were:<br><br>Gary Guiles, RN, HFS, Team Leader<br>Teresa Hamblin, RN, MS, HFS<br>Weslianne Lewis, RN, BSN, HFS | E 000 | RECEIVED<br>DEC 07 2018<br>FACILITY STANDARDS | |

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

R.N. | PRESIDENT | 11/30/18

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.