IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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PHONE 208-334-6626
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February 2, 2012

Vicki Salerno, Administrator
Care At Home
501 North 16th Street, Suite 112
Payette, ID 83661

RE: Care At Home, Provider #137068

Dear Ms. Salerno:

This is to advise you of the findings of the Medicare/Licensure survey at Care At Home, which was concluded on January 13, 2012.

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 **February 15, 2012**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626.

Sincerely,

Teresa Hamblin RN, MS

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srm
Enclosures

Care at Home

March 9, 2012

Plan of Correction Addendum per our phone conversation on Friday, March 2, 2012. Teresa Hamblin, RN, MS, Surveyor and Vicki Salerno, MS, RD, Administrator.

1. Please see revised organizational chart attached.

2. Tag G143:
   In addition to utilizing our Case Manager Admit form we will adhere to the following procedures for changes that occur during the certification period. Field clinicians who notice a change in a patient condition will note this change on their visit sheet. The clinician will also notify the case manager. The case manager will follow up by using our communication note system to notify any appropriate personnel, including the physician as necessary. An interim order will be obtained from the physician if needed. Clinicians will also notify the physician from the patient's home if possible and then follow up with the case manager. All clinician notes will be reviewed by the case manager or designee.

3. Tag G158:
   If visit frequencies must be changed during the certification period, the clinician will notify the case manager and orders will be obtained from the physician. The Outlook calendar will be updated for the case manager.

4. Tag G159:
   If there are changes regarding equipment, supplies, or medications during the certification period, the clinician will notify the case manager. If the changes are regarding medications, the medication list will be updated. An interim order will serve as an update to the Plan of Care.

5. Tag G225:
   An exception report in Home Solutions will be made available to the supervising nurse or therapist for review prior to the home health aide supervisory visit. If any deviations from the Plan of Care are found the aide will be educated to follow the Plan of Care and to write a communication note with any explanation. The supervisor will document findings on the supervisory note and any follow up necessary.

6. Tag N199
   All background check information will be filed in each personnel file within 7 days of receipt.

Vicki Salerno, Adm.

501 N. 16th St. ~ Payette, Idaho 83661 ~ (208)642-1838 ~ Fax: (208)642-3088

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137068	A. BUILDING _____ B. WING _____	01/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE AT HOME	501 NORTH 16TH STREET, SUITE 112 PAYETTE, ID 83661

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G 000	INITIAL COMMENTS The following deficiencies were cited during a recent recertification survey of your home health agency. The surveyors conducting the recertification were: Teresa Hamblin, RN, MS, HFS, Team Leader Rebecca Lara, RN, BA, HFS Acronyms used in this report include: ALF = Assisted Living Facility BP = Blood Pressure CAD = Coronary Artery Disease CAHPS = Consumer Assessment of Healthcare Providers and Systems CHF = Congestive Heart Failure CMS = Centers for Medicare and Medicaid Services CPAP = Continuous Positive Airway Pressure HHA = Home Health Agency LPN = Licensed Practical Nurse MD = Medical Doctor MLS = Milliliters MSW = Medical Social Worker P = Pulse POC = Plan of Care PT = Physical Therapist RD = Registered Dietician RN = Registered Nurse SOC = Start of Care SPO2 = Saturation of Peripheral Oxygen T = Temperature UA = Urinalysis UTI = Urinary Tract Infection	G 000	RECEIVED FEB 15 2012 FACILITY STANDARDS	
G 123	484.14 ORGANIZATION, SERVICES & ADMINISTRATION	G 123		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Vicki Salerno | TITLE: Administrator | (X6) DATE: 2.14.12

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 123	Continued From page 1 Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable. This STANDARD is not met as evidenced by: Based on review of agency paperwork and administrative documents, an onsite visit to an off-site location, email communication with CMS and the Oregon State Agency, and staff interview, it was determined the agency failed to ensure administrative control and lines of authority were clearly set forth in writing and readily identifiable. This resulted in a lack of clarity related to organizational control and lines of authority, particularly as it related to off-site locations. Findings include: At the entrance conference on 1/09/12 starting at 9:35 PM, the Director of Professional Services stated the agency had branch locations in Council, Idaho, and Caldwell, Idaho. She stated the agency also had a location in Baker City, Oregon. She said the Administrator was on her way to the office and would be a better person to talk with about the Baker City location. The Administrator joined the exit conference a short time later. She voiced uncertainty as to whether the location in Baker City was a subunit. She stated she made a trip to Portland, Oregon, in 2011, where an in-office licensing survey of the Baker City location was completed by the Oregon State Survey Agency, and a license was issued.	G 123	Tag: G123 Specific Action Taken: Organizational chart is redone to reference offsite locations and clarify supervisory relationships. Please see attached chart. We have been in contact with Kate Mitchell at CMS Region X and the Oregon State surveyors regarding the Baker City location. We participated in a teleconference with Ms. Mitchell, two Oregon State surveyors, and their supervisor on February 7, at 11:00 a.m. The Baker City location is a licensed, free standing parent agency and as such has no supervisory relationship on the above organizational chart. The Caldwell location is currently within our Payette parent agency service area. Skilled patients will only be accepted and seen under the Payette agency. Skilled staff will continue to use the Caldwell location as a drop site for patient notes to be transported to the Payette office.	

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G 123	Continued From page 2 On 1/09/12, upon request, the Administrator provided surveyors with a copy of an undated organizational chart, "Care at Home, Inc. Organizational Chart." The Organizational Chart showed "Nursing Services" as responsible for oversight of the RD. However, the only RD on staff was the Administrator, who supervised the Director of Professional Services. The chart did not identify any of the 3 off-site locations (Council, Idaho; Caldwell, Idaho; Baker City, Oregon), or refer to other organizational charts to further identify and clarify supervisory relationships. The chart included a box with the word "subunit" written in it. Surveyors initiated communication with the Oregon State Survey Agency. Email communication from the Oregon State Survey Agency on 1/11/12 at 2:35 PM, indicated the location in Baker City, Oregon, was not a branch or subunit, but a separately licensed parent agency, which was not yet Medicare certified. The reference to a subunit on the organizational chart was incorrect. The Administrator and Director of Professional Services were interviewed together on 1/10/12 at 9:45 AM. They acknowledged the organizational chart did not reference off-site locations and stated the "Baker branch" had its own organizational chart "because it was required for Oregon licensure." They stated the Director of Professional Services, an RN, provided nursing oversight for Payette, Caldwell and Council and another RN provided on-site nursing oversight at the Baker City location. The Therapy Director, located at the Payette site, provided oversight of therapists for all 4 locations. These lines of	G 123	Continued from page 2 We have sent a letter of request for branch status to the State of Idaho, Bureau of Facility Standards. We have also submitted a CMS form 855 request for branch status to our fiscal intermediary, NGS. We received a phone call from NGS on February 8, 2012, asking why we are submitting another 855 for this purpose since we have already been listed in PECOS as a branch for a year and a half. We asked for them to communicate with us regarding this status and any other information we might need to provide. Systemic/Policy Adjustments: Please see above specific actions taken. Monitoring: The administrator will continue to follow up with the State of Idaho regarding any other needed information to complete the branch office status request. Date of Compliance: February 15, 2012.	

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G 123	Continued From page 3 authority were not clearly set forth in writing on the organizational chart. Surveyors visited the off-site location in Caldwell on 1/10/12 between 4:30 PM and 5:05 PM. Surveyors were greeted by two individuals who identified themselves as CNA's and "Schedule Coordinators." They explained they scheduled the CNA visits for two businesses, Care Continuum and Care at Home, and homemaker services for one business, Care Continuum. One of the Schedule Coordinators gave a tour of the facility to the surveyors, pointing out desks, copier, computers, conference room, mail room, and break room. She stated the office was used by physical therapists, occupational therapists, an RN, and CNA staff. She stated one or two nurses picked up their mail at the Caldwell site. During the tour of the facility, surveyors met another individual who identified herself as the Office Manager. She stated she provided oversight to the CNAs and caregivers operating from the Caldwell location, including staff that provided care for both businesses. She further stated the Director of Professional Services at the Payette City location supervised the CNAs. She stated she (the Office Manager) was an employee of the home health agency, the CNAs were employed by Care Continuum (not the home health agency), and all skilled staff were employed by Care at Home (the home health agency). When asked to identify her direct supervisor, she stated she reported to the Administrator of the home health agency and she also communicated with the Director of Professional Services.	G 123		

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G 123	Continued From page 4 The supervisory relationships at the Caldwell location were not represented on the agency's organizational chart. The agency had only one CMS-approved branch location, which was in Council, Idaho. The agency was operating a branch in Caldwell, which was not CMS-approved. This was confirmed via email communication with the CMS Region X Office on 1/10/12 at 2:43 PM. The agency did not clearly set forth in writing lines of authority for all locations.	G 123		
G 135	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, ensures the accuracy of public information materials and activities. This STANDARD is not met as evidenced by: Based on review of agency policies, brochures, public information material, observation during a visit to an off-site agency location, and staff interview, it was determined the agency failed to ensure accuracy of public information materials and activities for 1 of 3 (Caldwell) of the agency's Idaho locations. This resulted in misrepresentation of home health agency services and of off-site locations as CMS approved branches. Findings include: 1. An agency policy, "Responsibilities of the Administrative Director," effective 11/93, included the expectation the Administrative Director would ensure accuracy of public information materials and activities. This did not occur, according to	G 135		

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G 135	Continued From page 5 agency policy. On 1/10/12 between 4:30 PM and 5:05 PM, surveyors visited an off-site agency location at 504 N 10th in Caldwell, Idaho. There was a large, elevated sign facing 10th Street with the agency name, "Care at Home." The glass entry door, facing Denver Street included the following information: Care at Home Office Hours Monday through Friday 9:00 AM to 5:00 PM, 24 hour on call 208-453-2659. Surveyors were greeted by two individuals who identified themselves as CNA's and "Schedule Coordinators." They explained they scheduled the CNA visits for two businesses, Care Continuum and Care at Home, and homemaker services for one business, Care Continuum. One of the Schedule Coordinators gave a tour of the facility to the surveyors, pointing out desks, copier, computers, conference room, mail room, and break room. She stated the office was used by physical therapists, occupational therapists, an RN, and CNA staff. She stated one or two nurses picked up their mail at the Caldwell office. During the tour of the facility, surveyors met another individual who identified herself as the Office Manager. She stated she provided oversight to the CNAs and caregivers operating from the Caldwell location, including staff that provided care for both businesses. She said the Director of Professional Services at the Payette City location supervised the CNAs. She stated	G 135	Tag: G 135 Specific Action Taken: At the Caldwell location under the Care At Home sign is a large reader board. Until the branch designation is official, we will utilize both sides of the reader board to list Care Continuum as the provider of In Home Care Services. Our blood pressure/blood glucose monitoring cards are distributed as a public service for individuals to use when visiting their physician to report on their levels. They do not specify skilled versus non-skilled status. The Caldwell location when identified by the sign as Care Continuum, will continue to serve non-skilled clients. Our brochure information will be altered immediately to reflect that non-skilled services are offered through Care Continuum. Our Care At Home admission binders are separate for skilled care. The binder with the Care Continuum letter is only given to non-skilled clients.	

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G 135	Continued From page 6 she (the Office Manager) was an employee of the home health agency, the CNAs were employed by Care Continuum (not the home health agency), and all skilled staff were employed by Care at Home (the home health agency). When asked to identify her direct superviser, she stated she reported to the Administrator of the home health agency and she also communicated with the Director of Professional Services. Information at the site was co-mingled so that it was not clear which business entity provided which service. This public information gave the impression the Caldwell site was a branch of the home health agency. The location had not been approved by CMS. This was confirmed via email communication with the CMS Region X Office on 1/10/12 at 2:43 PM. Also, the Medical Records Specialist who transmitted OASIS data was interviewed on 1/11/12 between 9:08 AM and 9:45 AM. She explained OASIS data was submitted for the Caldwell location under the Payette CMS-identification number. She stated the Caldwell location did not have a CMS-assigned branch identification number. 2. Written agency information, including "Blood Pressure & Blood Glucose Record," a "Care at Home" brochure, the front of a patient Admission packet, and the agency's website (www.careathomehh.com), listed 3 Idaho locations for the home health agency, including: 501 N 16th St., Suite 112 Payette, ID 83661	G 135	Continued from page 6: Systemic/Policy Adjustments: See above actions. Monitoring: Administrator will follow up to ensure that the above actions are taken. Date of Compliance: February 15, 2012	

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G 135	Continued From page 7 203 Illinois Ave., Suite C Council, ID 83612 504 N 105th Ave. Caldwell, ID 83605 Only two of the locations, the parent location in Payette and the branch in Council, had CMS approval. The administrator did not ensure accuracy of public information materials. 3. A Care at Home brochure listed services the agency did not actually provide, but instead were provided by a second business, Care Continuum. The Care at Home brochure stated "These services range from housekeeping and sitters to skilled nursing and skilled therapy," and include housekeepers, respite care/sitters, meal preparation, grocery shopping, laundry, and Alzheimer's care. The brochure stated "Maybe you are the primary caregiver for a loved one with a long-term illness, and you need a break. Are you looking for someone trustworthy and skilled to care for your child? Is it hard for you to drive and you need someone to run errands?" Skilled services were provided by the agency, Care at Home, and non-skilled services were provided by Care Continuum. The brochure co-mingled the services of two businesses while only identifying the home health agency. 4. The Care at Home admission binder, contained a letter that stated: "Dear Valued Client: You have chosen to receive services through Care Continuum." This information was not accurate. The client chose to receive	G 135		

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G 135	Continued From page 8 services through Care at Home, a home health agency that provided skilled services, not Care Continuum which provided unskilled services. The agency's public information was inaccurate.	G 135		
G 141	484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications and licensure that are kept current. This STANDARD is not met as evidenced by: Based on staff interview and review of personnel files, it was determined the agency failed to ensure the personnel files of 2 of 16 (Staff C and E) home health agency staff included evidence of current licensure. This had the potential to result in services provided by unqualified staff. Findings include: 1. Staff E, a physician, was hired on 9/01/93. When reviewed on 1/10/12, evidence of current Idaho and Oregon licenses could not be found in his personnel file. The Idaho license had an expiration date of 6/30/10 and the Oregon license showed an expiration date of 12/31/11. On 1/12/12, the Director of Nursing was provided a list of personnel files that did not appear to include current licences and asked to have the staff responsible review the files and flag any documents missed by the surveyor. Staff E's personnel file was reviewed again on 1/13/12. It included a document printed on 1/11/12, showing Staff E was currently licensed in Idaho and	G 141	Tag: G141 Specific Action Taken: Both of these personnel files were complete during the survey with current licenses. Systemic/Policy Adjustments: In our Home Solutions software system we are able to generate a report that identifies employee requirements due. We will now designate all contractors as employees in name within the system for the purpose of monitoring this report.	

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G 141	Continued From page 9 Oregon. The human resource staff person responsible for ensuring personnel files were complete was interviewed on 1/13/12, starting at 3:00 PM. She verified the file did not include evidence of current licensure prior to 1/11/12. Staff E's personnel files did not include evidence of current licensure. 2. Staff C, a speech therapist, was hired on 5/01/10. She provided services in Idaho and Oregon. When reviewed on 1/10/12, evidence of an Oregon license could not be found in her personnel file. On 1/12/12, the Director of Nursing was provided a document which included a question as to whether Staff C was licensed in Oregon and if so was the license current. When reviewed again on 1/13/12, Staff C's file included a document printed on 1/13/12, showing Staff C was licensed in Oregon and the license was current. The human resource staff person responsible for ensuring personnel files were complete was interviewed on 1/13/12, starting at 3:00 PM. She verified Staff C's personnel file did not include evidence of a current Oregon license prior to 1/13/12. Staff C's personnel files did not include evidence of current licensure.	G 141	Continued from page 9: Monitoring: We will continue to run this report monthly and notify all employees and contractors of any requirements due. We will not schedule anyone to work if they have outstanding requirements. The Human Resources Specialist will be responsible to monitor these requirements. Date of Compliance: February 15, 2012	
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.	G 143		

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G 143	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the agency failed to ensure effective communication and coordination among all personnel and services providing care to 5 of 12 sample patients, (#1, #4, #6, #7, and #10) whose records were reviewed. This failure had the potential to negatively impact patient care and safety. Findings include: 1. Patient #1 was an 88 year old male who was admitted to the agency on 2/11/11 for care related to a cerebral vascular accident (rapid loss of brain function due to an interruption in blood supply to the brain.) The RN "Start or Resumption of Care" assessment, dated 7/12/11, from 11:30 AM to 1:00 PM, included recommendations for skilled nursing, physical therapy and home health aide services. It also included recommendations for a social services evaluation of mental status and home safety. There was no documentation to indicate the RN communicated with the Director of Professional Services or MSW regarding this expectation or had requested an order from the patient's physician. On 8/01/11, a "Transfer to Inpatient Facility" form was completed by the Director of Professional Services, which documented Patient #1 was transferred to an acute care facility related to a fall in the home. On 1/12/12, from 3:30 PM to 3:45 PM, the RN who completed the SOC assessment was interviewed. The RN reviewed Patient #1's record and confirmed the social services evaluation had not occurred. She remembered	G 143	Tag: G143 Specific Action Taken: We have created a new work sheet that is included with the Start of Care packet to be utilized by the case manager upon review of the assessing professional's notes. It identifies additional information that must be included in the Plan of Care. It also helps to identify other disciplines that need to be contacted with information or referrals. It helps to clarify visit frequencies and any need for additional orders. This new procedure will ensure effective communication and coordination of care. The Director of Professional Services and the Therapy Director will inservice all professional staff regarding coordination of care and medication reconciliation. Evidence of inservice will be included in personnel files.	

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	137068	A. BUILDING _____ B. WING _____	01/13/2012

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G 143	Continued From page 11 discussing safety concerns with Patient #1's daughter, who lived out of State. The RN stated the daughter believed Patient #1 was spending a great deal of time alone in the home and he was becoming increasingly weak. The RN stated she did not know why a physician order for a social services evaluation had not been requested. She was unable to recall communicating with the DON or MSW about the need for social services. On 1/12/12, from 4:20 PM to 4:30 PM, the Director of Professional Services was interviewed. She reviewed Patient #1's record and confirmed the evaluation by social services was never ordered and should have been. Effective coordination of care was not maintained. 2. Patient #6 was an 88 year old male who was admitted to the agency on 11/29/11 for care related to a wound that was not healing on his upper, left back. He was also diagnosed with congenital anomalies of the gall bladder, bile duct and liver, as well as dementia, hypertension, CHF, renal disease and CAD. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 11/29/11 and untimed, for the certification period, 11/29/11 through 1/27/12, documented an order for oxygen, 2 liters per nasal cannula at night, in the medication section of the assessment. Documented under the "Treatments and Orders" section of the assessment, was the following statement: "Pt is on 2 L continuous oxygen." On the "Physician Interim Order," dated 12/23/11 and untimed, there was an order for skilled nursing to assess Patient #6's cardiopulmonary status, including vital signs, oxygen saturation levels, lung sounds	G 143	Continued from page 11: Systemic Policy Adjustments: Please see attached worksheet. Monitoring: Director of Professional Services and Therapy Director will be responsible to institute this new review procedure. Date of completion: March 15, 2012	

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G 143	Continued From page 12	G 143		

and level of edema. The documented ranges for vital signs and oxygen saturation were as follows: "BP 90/60, P 60-90, T 96.0-99.5, SpO2 (oxygen saturation) > 89%, clear lung sounds, and edema < 1+ thru cert period. Notify MD if SpO2 < 90%, lung sounds and level of edema."

A visit was conducted on 1/10/12, from 2:10 PM to 3:00 PM, with Patient #6. He resided in an ALF at the time of the visit. The RN was observed while she performed a dressing change and assessed Patient #6. While assessing Patient #6's cardiopulmonary status, the RN found the oxygen saturation rate to be at 80% on room air. The RN had to coach Patient #6 in proper breathing technique. As a result, he was able to finally achieve an oxygen saturation rate of 83%. The RN assessed Patient #6's breath sounds with the use of a stethoscope and stated she heard wheezes in both lungs. The surveyor was able to hear Patient #6 wheezing without the use of a stethoscope. The agency RN and ALF Administrator, who was also an RN, were interviewed about the abnormal findings at the time of the visit. They were also interviewed about the process for coordination of care between the agency and ALF. There was confusion about whose responsibility it was to coordinate care and report the abnormal findings to the physician. It was decided the ALF Administrator would do so. When discussing how coordination of care occurred between the agency and ALF, the agency RN stated it was her practice to discuss visit results with the ALF Administrator at the time of each visit. The RN also stated she left copies of her documentation in the ALF record, however, when the surveyor checked the ALF record for Patient #6, no agency

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G 143	Continued From page 13 documentation was found. The agency RN then stated copies of her visit notes would be faxed to the ALF before the end of the day. The agency RN was interviewed on 1/12/12, from 1:00 PM to 1:25 PM. Coordination of care between an ALF and the agency was discussed. When asked who was responsible for coordinating care with the physician in charge of Patient #6's care, she stated the ALF was responsible for communicating changes to the physician. The Director of Professional Services was interviewed on 1/12/12, from 3:10 PM to 3:20 PM. She reviewed Patient #6's medical record and coordination of care between the agency and ALF was discussed. When asked who was responsible for communicating condition changes and abnormal findings to the physician, the Director initially said she thought the ALF was responsible, but later stated she understood the agency had responsibility for coordinating with the physician. The RN failed to maintain liaison with all personnel furnishing services to Patient #6. 3. Patient #7 was a 67 year old woman who was admitted to the agency on 10/29/11 for aftercare following surgery to the left jaw area related to a neoplasm (abnormal mass of tissue or tumor.) The RN "Start or Resumption of Care" assessment, dated 11/26/11, from 1:00 PM to 2:30 PM, documented Patient #7 was allergic to sulfa and morphine. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 10/29/11 and untimed, for the certification period,	G 143		

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G 143	Continued From page 14 12/28/11 through 2/25/12, ordered skilled nursing and physical therapy services and documented Patient #7 was allergic to morphine but failed to identity the allergy to sulfa. The 'Patient Medication List," dated 12/22/11 at 11:33 AM documented Patient #7 was allergic to codeine, morphine and sulfa. Also included on the medication list was an order for Tylenol with codeine, to be taken on an "as needed" basis. There was no documentation indicating the RN had discussed the medication/allergy discrepancies with Patient #7, the Director of Professional Services, the physician or other disciplines assigned to care for Patient #7. A home visit was conducted on 1/10/11, from 1:07 PM to 2:00 PM. The physical therapist was observed while working with Patient #7 on strength, balance and stretching exercises, as well as gait training. When asked how coordination of care between disciplines occurred, the PT stated she either contacted the RN by phone or spoke to her in person when in the office. She also stated it was a small community and she discussed Patient #7 with the physician when she saw him at the local hospital. The PT stated those discussions were not consistent with documentation. The PT was unaware of a formal process for coordinating care. The Director of Professional Services was interviewed on 1/12/12, from 2:50 PM to 3:05 PM. She reviewed Patient #7's record and confirmed there were discrepancies in the record related to Patient #7's list of allergies. The Director also confirmed Tylenol with codeine was ordered, and Patient #7 had a documented allergy to codeine.	G 143		

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G 143	Continued From page 15 She agreed effective coordination of care did not occur. Effective communication and coordination of care was not maintained between the RN, PT and physician assigned to care for Patient #7. 4. Patient #10 was a 83 year old male who was admitted to the agency on 12/08/11 with diagnoses that included a UTI with urinary catheter placement. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 12/08/11 and untimed, for the certification period, 12/08/11 through 2/05/12, did not include an order for bactrim DS, an antibiotic to treat the UTI. A "Nursing Intervention" visit note dated 12/29/11, from 2:50 PM to 3:35 PM, documented the LPN contacted the physician's office to check on "UTI treatment." The visit note also stated the physician would call a medication in to the pharmacy. The "Patient Medication List," dated 12/20/11 at 2:51 PM, documented a hand written entry for bactrim DS, to be taken twice a day, for 10 days, beginning 12/29/11. A home visit was conducted on 1/12/12, from 9:00 AM to 9:50 AM. The LPN was observed while providing care to Patient #10. During the visit, Patient #10's care giver/daughter was interviewed. When asked if she had any concerns about the care being provided by the agency, she stated she was satisfied with the care her father was receiving, but had a concern. The daughter described a "mix up" related to an antibiotic prescription for Patient #10. She then stated the mix up caused a delay of approximately one week between the time the physician ordered the antibiotic and Patient #10	G 143		

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G 143	Continued From page 16	G 143		

started the new medication. It was the daughter's understanding that the agency would pick up the antibiotic and deliver it to the home of Patient #10.

An interview was conducted with the Director of Professional Services on 1/12/12, from 2:00 PM to 2:15 PM. She reviewed Patient #10's record and confirmed there was a delay in Patient #10 beginning the antibiotic because the physician's office delayed faxing the order to the agency. The Director of Professional Services also stated it was not a postponement of a week, but only a few days. She also said it was not the practice of the agency to pick up medications at the pharmacy and deliver them to a patient.

Also during the home visit on 1/12/12 from 9:00 AM to 9:50 AM, the LPN was observed during a Foley catheter change. The balloon was not tested by inflating with sterile solution prior to the insertion of the catheter. Once the catheter was inserted, Patient #10 complained of pain when the balloon was inflated, and there was no flash back/return of urine as expected.

An interview was conducted with the Director of Professional Services on 1/12/12, from 2:00 PM to 2:15 PM. The Foley catheter change that was performed by the LPN during the 1/12/12 visit was also discussed. Until the surveyor informed her of the observation, the Director was unaware that Patient #10 stated he was in pain when the LPN inflated the catheter balloon. She was also unaware there was no flash back/return of urine at the time the catheter was inserted.

An agency administrative policy, AP-15, effective

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G 143	Continued From page 17 date 11/93, on the subject of skilled nursing documented the following under the subsection of home visits: the nurse is responsible for "notifying the physician or appropriate Agency personnel of any significant changes." Effective liaison was not maintained between the LPN, Director of Professional Services and the physician related to the care of Patient #10. 5. Patient #4 was a 76 year old male who was admitted to the agency on 9/22/11 for care related to diabetes and an open wound on his toe. A physical therapy visit note, dated 12/02/11 at 4:20 PM, documented Patient #4 was instructed by his physician to increase the dosage of his diuretics. There was no documentation the PT had communicated the change in dosage to the Case Manager or another RN so the dosage change could have been verified with the physician and the medication sheet updated. The Director of Professional Services was interviewed on 1/12/12 at 3:50 PM. She reviewed Patient #4's record and stated she agreed the information had not been communicated to an RN, the dosage had not been clarified, and the medication list had not been updated in Patient #4's record. She explained that generally when a physical therapist becomes aware of a change, the information is communicated to the Case Manager or to her. The agency did not ensure physical therapy staff coordinated with nursing staff to ensure a medication change was confirmed and updated in	G 143		

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G 143	Continued From page 18 Patient #4's record.	G 143		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure prior physician approval of visit frequency occurred for 3 of 12 patients (#2, #4, and #8) whose records were reviewed. This resulted in PT and aide visits without prior physician authorization. Findings include: 1. Patient #2 was an 88 year old male who was admitted to the agency on 7/11/11 for care related to a non-healing surgical wound. Physician orders, dated 11/23/11, included orders for physical therapy to visit 1 time per week for the first week followed by 2 times per week for 4 weeks for a total of 5 weeks of physical therapy. Physical therapy visit notes, 12/30/11 at 1:05 PM and 1/04/12 at 2:23 PM, were present in the record. These visits were during the 6th and 7th week of service, and exceeded the physician order for 5 weeks. The Director of Professional Services was interviewed on 1/12/12 at 2:45 PM. She reviewed Patient #2's record and confirmed physician orders were missing for the two visits. She stated she would have obtained physician orders retroactively after a chart audit when the visit discrepancy would have been found.	G 158	Tag: G158 Specific Action Taken: We have created a new work sheet that is included with the Start of Care packet to be utilized by the case manager upon review of the assessing professional's notes. It identifies additional information that must be included in the Plan of Care. It also helps to identify other disciplines that need to be contacted with information or referrals. It helps to clarify visit frequencies and any need for additional orders. This new procedure will ensure effective communication and coordination of care. The Director of Professional Services and the Therapy Director will inservice all professional staff regarding coordination of care. Evidence of inservice will be included in personnel files.	

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G 158	Continued From page 19 Physical therapy visits did not follow a written plan of care for number of authorized visits. 2. Patient #4 was a 76 year old male who was admitted to the agency on 9/22/11 for care related to diabetes and an open wound on his toe. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE (Form 485)" for certification period 11/21/11 to 1/19/12 included orders for physical therapy to visit Patient #4 weekly for 4 weeks. A fifth unauthorized visit was made on 12/23/11 during the fifth week of service. There were no additional orders to demonstrate approval for the fifth physical therapy visit. The Director of Professional Services was interviewed on 1/12/12 at 3:50 PM. She reviewed Patient #4's record and stated she confirmed an order was missing to authorize the fifth visit. She stated she generally writes retrospective physician orders when extra visits are found during a chart audit. Physical therapy visits did not follow a written plan of care for number of authorized visits. 3. Patient #8 was a 78 year old patient who was admitted to the home health agency on 1/01/12 for care related to a leg injury, weakness, and pneumonia. An "Aide Intervention" visit note, dated 1/04/12 at 9:45 AM, documented the aide gave Patient #8 a shower, provided skin care, grooming assistance, and housekeeping. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE (Form 485)" for certification period 12/16/11 to 2/14/12 did not include a plan for	G 158	Continued from page 19: Systemic Policy Adjustments: Please see attached worksheet regarding Frequency/duration of visits ordered and Outlook calendar for visit frequency/range expiration. Please note also on the worksheet coordination of care/services ordered regarding Home Health Aide. Monitoring: Director of Professional Services and Therapy Director will be responsible to institute this new review procedure. Date of Compliance: March 15, 2012	

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G 158	Continued From page 20 home health aide services. There were also no documented physician orders for home health aide services. The Director of Professional Services was interviewed on 1/10/12 at 10:50 AM. She reviewed Patient #8's record and confirmed the home health aide visit was conducted without physician orders. In the afternoon of 1/10/11, the Director of Professional Services provided a copy of an order for home health aide services, dated 12/28/11, and signed by the physician on 1/10/11. When asked if she found a missing order, she stated she created it that day, 1/10/11. The order was obtained retrospectively. Home health aide services did not follow a written plan of care.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on record review, policy review, observation during a home visit, and staff interview, it was determined the agency failed to	G 159	G: 159 Specific Action Taken: We have created a new work sheet that is included with the Start of Care packet to be utilized by the case manager upon review of the assessing professional' notes. It identifies additional information that must be included in the Plan of Care. It also helps to identify other disciplines that need to be contacted with information or referrals. It helps to clarify visit frequencies and any need for additional orders.	

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G 159	Continued From page 21 ensure the plan of care included all pertinent information for 6 of 12 patients (#1, #5, #6, #7, #11, and #12) whose records were reviewed. This had the potential to interfere with continuity and coordination of patient care. Findings include: An agency policy, "Plan of Treatment," effective 11/93, stated the plan of treatment should include medications, treatments, medical supplies, and orders for disciplines required. Pertinent items were missing from the plan of treatment, as follows: 1. Patient #5 was a 62 year old male who was admitted to the agency on 12/21/11 for care primarily related to a wound. The initial RN assessment, "Start or Resumption of Care," dated 12/21/11 at 2:15 PM, documented Patient #5 used a C-PAP with oxygen by mask at night and oxygen as needed during the day. The oxygen flow rate was documented to be 3 liters per minute. The assessment also stated Patient #5 used a gel cushion on his wheelchair and a slider board to transfer from his wheelchair. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE (Form 485)," did not include oxygen on the medication list. It also did not include the C-PAP, the oxygen equipment, the slider board, or the gel cushion as pertinent DME or supplies. The Director of Professional Services was interviewed on 1/12/12 at 3:10 PM. She reviewed Patient #5's record and confirmed the oxygen should have been included on the medication list. She stated she did not realize the DME and	G 159	Continued from page 21: This new procedure will ensure effective communication and coordination of care. The Director of Professional Services and the Therapy Director will inservice all professional staff regarding coordination of care. The inservice will also include education that it is the responsibility of the nurse/therapist to clarify MD orders. Evidence of inservice will be included in personnel files. Systemic/Policy Adjustment: See attached worksheet line DME/ supplies; line Medication/Oxygen; line Coordination of care/services/Aide; line Frequency/duration of visits ordered; line/Medication/OTC treatments; line Coordination of care/services/Social Worker; line allergies compared to med list. Monitoring: Director of Professional Services and Therapy Director will be responsible to institute this new review procedure and inservice the nursing and therapy staff.	

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G 159	Continued From page 22 equipment should have been included on the plan of care. The plan of care did not include all medications and equipment required. 2. Patient #11 was a 50 year old male who was admitted to the agency on 3/03/11 for care primarily related to diabetes. The initial RN assessment, "Start or Resumption of Care," dated 12/24/11 at 2:20 PM, documented Patient #11 was on intermittent oxygen at 2 liters via nasal cannula. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE (Form 485) did not include oxygen as a medication, or oxygen equipment as relevant DME. Also, the plan of care included orders for home health aide services 1-2 times per week but did not include orders for the length of time services were to be provided. The Director of Professional Services was interviewed on 1/12/12 at 3:25 PM. She reviewed Patient #11's record and confirmed oxygen and oxygen equipment were not on the plan of care. She confirmed the order for home health aide services was incomplete. The plan of care did not include oxygen, oxygen equipment, or a complete order for aide services. 3. Patient #12 was a 68 year old male who was admitted to the agency on 10/28/11 for care related to Parkinson's disease and difficulty swallowing. The RN Recertification Assessment, dated 12/26/11 at 5:05 PM, listed items relevant to the plan of care, including antibiotic ointment, an elevated toilet seat, grab bars, and a	G 159	Continued from page 22: Date of completion: March 15, 2012	

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	137068	A. BUILDING _____ B. WING _____	01/13/2012

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G 159	Continued From page 23 tub/shower bench. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE (Form 485)," for certification period 12/27/11 to 2/24/12, did not include any of these items. The plan of care included orders for bath aide assistance 1-2 times per week. It did not specify how many weeks the bath aide should provide assistance. The Director of Professional Services was interviewed on 1/12/12 at 1:45 PM. She reviewed Patient #12's record and confirmed the items were not included on the plan of care and the aide visit schedule was incomplete. The plan of care did not include all relevant medication, equipment, and did not include the duration of home health aide visits. 4. Patient #1 was an 88 year old male who was admitted to the agency on 2/11/11 for care related to a cerebral vascular accident (rapid loss of brain function due to an interruption in blood supply to the brain.) The RN "Start or Resumption of Care" assessment, dated 7/12/11, from 11:30 AM to 1:00 PM, indicated the need for a social services evaluation to assess Patient #1's mental status and home safety. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 7/12/11 and untimed, for the certification period 7/12/11 to 9/09/11, did not include an order for a social services evaluation. On 8/01/11, a "Transfer to Inpatient Facility" form was completed by the Director of Professional Services, which documented Patient #1 was transferred to an acute care facility related to a fall in the home.	G 159		

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G 159	Continued From page 24 On 1/12/12, from 3:30 PM to 3:45 PM, the RN who completed the SOC assessment was interviewed. She remembered discussing safety concerns with Patient #1's daughter, who lived out of state. The RN stated the daughter believed Patient #1 was spending a great deal of time alone in the home and he was becoming increasingly weak. The RN confirmed the social services evaluation was not included on the POC and was therefore not ordered. On 1/12/12, from 4:20 PM to 4:30 PM, the Director of Professional Services was interviewed. She reviewed Patient #1's record and confirmed the evaluation by social services was not included on the POC and should have been. The POC for Patient #1 failed to include an order for a social services evaluation. 5. Patient #6 was an 88 year old male who was admitted to the agency on 11/29/11 for care related to a wound that was not healing on his upper, left back. He was also diagnosed with congenital anomalies of the gall bladder, bile duct and liver, as well as dementia, hypertension, CHF, renal disease and CAD. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 11/29/11 and untimed, for the certification period, 11/29/11 through 1/27/12, documented an order for oxygen, 2 liters per nasal cannula at night, in the medication section of the assessment. Documented under the "Treatments and Orders" section of the assessment, was the following statement: "Pt is on 2 L continuous oxygen."	G 159		

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G 159	Continued From page 25 A visit was conducted on 1/10/12, from 2:10 PM to 3:00 PM, with Patient #6. He resided in an ALF at the time of the visit. The RN was observed while she performed a dressing change and assessed Patient #6. While assessing Patient #6's cardiopulmonary status, the RN found the oxygen saturation rate to be at 80% on room air. The RN had to coach Patient #6 in proper breathing technique. As a result, he was able to finally achieve an oxygen saturation rate of 83%. She also stated she heard wheezes in both lungs. Patient #6 was not wearing oxygen during the visit. The RN and ALF Administrator, who was also an RN, were interviewed and stated oxygen was ordered for Patient #6 at 2 liters per nasal cannula, at night only. The agency RN was interviewed on 1/12/12, from 1:00 PM to 1:25 PM. She reviewed Patient #6's medical record and confirmed there were two different orders for oxygen on the POC. The RN agreed the orders should have been clarified and the POC should have been corrected/updated. The Director of Professional Services was interviewed on 1/12/12, from 3:10 PM to 3:20 PM. She reviewed Patient #6's medical record and confirmed the discrepancy on the POC related to oxygen orders. The Director agreed the POC was inaccurate and should have been corrected. The plan of care for Patient #6 was unclear and failed to document accurate instructions/orders for the therapeutic use of oxygen. 6. Patient #7 was a 67 year old woman who was admitted to the agency on 10/29/11 for aftercare following surgery to the left jaw area related to a	G 159		

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G 159	Continued From page 26 neoplasm (abnormal mass of tissue or tumor.) The RN "Start or Resumption of Care" assessment, dated 11/26/11, from 1:00 PM to 2:30 PM, documented Patient #7 was allergic to sulfa and morphine. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 10/29/11 and untimed, for the certification period, 12/28/11 through 2/25/12, ordered skilled nursing and physical therapy services and documented Patient #7 was allergic to morphine but failed to identify the allergy to sulfa. The Director of Professional Services was interviewed on 1/12/12, from 2:50 PM to 3:05 PM. She reviewed Patient #7's record and confirmed the POC should have included information related to the allergy to sulfa. The Director agreed the POC should have been corrected, but was not. The agency failed to ensure the POC was comprehensive and current.	G 159		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the agency failed to update the plan of care and alert the physician to changes in 1 of 6 patients (#7) who had home visits and whose records were reviewed. This had the potential to negatively impact patient care and interfere with the physician's ability to effectively manage patients' plans of care.	G 164	Tag: G164 Specific Action Taken: Inservice will be provided to nursing/ therapy staff that includes a reminder of agency policy AP-15 that requires communication with the physician in order to further develop the Plan of Treatment. This notification will occur as often as possible from the patient's home. This notification will be documented in the visit note which will be reviewed by the case manager or designee.	

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G 164	Continued From page 27 Findings include: 1. Patient #7 was a 67 year old woman who was admitted to the agency on 10/29/11 for aftercare following surgery to her left jaw area related to a neoplasm (abnormal mass of tissue or tumor.) The RN "Start or Resumption of Care" assessment, dated 11/26/11, from 1:00 PM to 2:30 PM, documented Patient #7 was allergic to sulfa and morphine. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 10/29/11 and untimed, for the certification period, 12/28/11 through 2/25/12, ordered skilled nursing and physical therapy services and documented Patient #7 was allergic to morphine but failed to identify sulfa as an allergy. The 'Patient Medication List," dated 12/22/11 at 11:33 AM documented Patient #7 was allergic to codeine, morphine and sulfa. It also documented an order for Tylenol with codeine, to be taken on an "as needed" basis. There was no documentation indicating the RN had alerted the physician to Patient #7's allergy to codeine and to clarify if he/she did intend to order a medication that included codeine. The Director of Professional Services was interviewed on 1/12/12, from 2:50 PM to 3:05 PM. She reviewed Patient #7's record and confirmed there were discrepancies in the record related to Patient #7's list of allergies. The Director of Professional Services also confirmed Tylenol with codeine was ordered, and Patient #7 had a documented allergy to codeine. She agreed this information should have been reported to the physician and was not. An agency administrative policy, AP-15, on the	G 164	Continued from page 27: Systemic/Policy Adjustment: See attached worksheet line Allergies compared to med list. Monitoring: Director of Professional Services and Therapy Director are responsible to review all visit notes and ensure that physician notification has occurred. Date of Compliance: March 15, 2012	

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G 164	Continued From page 28 subject of skilled nursing with an effective date of 11/93 documented the following : - Re-evaluating the patient's nursing needs as required. - Communicating findings with the physician in order to further develop the Plan of Treatment (POT). The agency failed to consistently alert the physician to changes in patients that suggested a need to alter the plan of care.	G 164		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, it was determined the agency failed to ensure care was provided as ordered by a physician for 2 of 12 patients (#4 and #11) whose records were reviewed This had the potential to result in provision of care without physician authorization. Findings include: 1. Patient #4 was a 76 year old male who was admitted to the agency on 9/22/11 for care related to diabetes and an open wound on his toe. A physical therapy visit note, dated 12/16/11, stated Patient #4's left leg was edematous and TED hose (compression stockings) had been ordered. There was no documented physician's order or approval for the compression stockings. The Director of Professional Services was	G 165	Tag: G165 Specific Action Taken: Inservice to skilled nurses and therapists referenced above will include education to obtain physician orders for any treatments. If these issues arise after the initial Plan of Care, the physician will be notified via interim order. Systemic/Policy Adjustments: No changes needed. Nursing/Therapy staff inserviced regarding agency policy AP-15, regarding communicating findings with the physician in order to further develop the Plan of Treatment.	

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G 165	Continued From page 29 interviewed on 1/12/12 at 3:50 PM. She reviewed Patient #4's record and stated it was agency practice to get a physician's order for compression stockings. She stated she did not see evidence of a physician's order in Patient #4's record. Compression stockings were initiated without physician approval or orders. 2. Patient #11 was a 50 year old male who was admitted to the agency on 3/03/11 for care primarily related to diabetes. An LPN visit note, dated 11/28 at 12:00, stated Patient #11 had toenail fungus started on great toes and will use mentholatum on toes. There was no documentation in Patient #11's record that mentholatum had been ordered or approved by a physician for the treatment of toenail fungus. The Director of Professional Services was interviewed on 1/12/12 at 3:25 PM. She reviewed Patient #11's record and stated the mentholatum was used per nursing judgment rather than per physician order. She explained that nurses in their agency were allowed to make recommendations related to some over-the-counter products. She considered them "home remedies." Toenail fungus treatment was initiated without physician approval or orders.	G 165	Continued from page 29: Monitoring: Director of Professional Services and Therapy Director will review all skilled visit notes and ensure that Physician notification has occurred. Date of Compliance: March 15, 2012	
G 182	484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse prepares equipment and materials for treatments, observing aseptic technique as required.	G 182		

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G 182	Continued From page 30 This STANDARD is not met as evidenced by: Based on an observation during a home visit, policy review and staff interview, it was determined the agency failed to ensure the LPN used aseptic technique during a Foley catheter change for 1 of 1 patient (#10) whose catheter change was observed during a home visit. This had the potential to interfere with infection prevention. Findings include: Patient #10 was an 83 year old male who was admitted to the facility on 12/08/11 whose diagnoses included a UTI, with urinary catheter placement. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 12/08/11 and untimed, for the certification period, 12/08/11 through 2/05/12, included orders for skilled nursing, physical therapy and home health aide services. The following order was included as well: "Assess/educate in s/s of UTI, catheter care, change catheter 1/month, PRN UA for symptoms or UTI." A home visit was conducted on 1/12/12, from 9:00 AM to 9:50 AM. The LPN was observed during a Foley catheter change. Aseptic technique was not maintained during the procedure. The LPN failed to connect the drainage bag, which would have created a sterile, closed system. Nor did she place a sterile tray between Patient #10's legs to keep the sterile end of the catheter from falling outside the sterile field. This resulted in the sterile end of the catheter falling outside the sterile field, causing potential contamination. The LPN also failed to cleanse the meatus, (insertion site of the	G 182	Tag: G182 Specific Action Taken: Director of Professional Services reviewed the appropriate technique with the licensed nurse to ensure skill level is appropriate. Licensed nurse was able to describe appropriate technique. During the nursing inservice the Director of Professional Services will review the agency policy and procedure regarding aseptic technique during a Foley catheter procedure. Systemic/Policy Adjustment: None needed Monitoring: The case manager or designee will conduct bi-weekly oversight of licensed nurse performance. Date of Completion: March 15, 2012	

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G 182	Continued From page 31 catheter,) with betadine swabs (anti-septic solution). The sterile work area was arranged on top of a surface that was unstable and too small. This allowed the sterile tray and sterile water filled syringe to fall to the edge of the sterile drape, causing a break in the sterile field. According to the "Third Edition of Mosby's, Nursing Interventions & Clinical Skills," the nurse should have arranged her work surface, on the Patient's bed, between his legs, using the sterile drapes to ensure a sterile work surface. Mosby also stated a closed system should be maintained by connecting the drainage bag to the catheter before inserting the catheter. Another option that Mosby allowed was placing the sterile end of the catheter in the sterile tray between the patient's legs while inserting the catheter. This prevents the catheter from falling outside the sterile field and allows for sterile container to collect the urine. Mosby also stated the meatus should be cleansed with betadine prior to the catheterization and once the catheter is in place, a urine return should be verified to ensure the catheter is properly located in the bladder and the catheter is adequately patent, or open for drainage of urine. The LPN was interviewed at the end of the home visit with Patient #10. She stated she was aware she had not maintained aseptic technique during the procedure, but that she was "nervous about being observed." An interview was conducted with the Director of Professional Services on 1/12/12, from 2:00 PM to 2:15 PM. She reviewed Patient #10's record and stated the LPN had been in communication with her related to the catheterization. The Director said the LPN reported she had not	G 182		

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G 182	Continued From page 32 maintained aseptic technique during the procedure. The Director confirmed it was the practice/policy of the agency for nurses to use aseptic technique during a Foley catheter procedure. An agency administrative policy, AP-15, on the subject of skilled nursing with an effective date of 11/93 documented the following under the subsection of the licensed practical nurse: "Duties: The licensed practical nurse shall provide services in accordance with the agency policies, prepare clinical and progress notes, assist the physician and/or registered nurse in performing specialized procedures, prepare equipment and materials for treatments, observe aseptic techniques as required, and assist the patient in learning designated self-care techniques." The agency did not ensure the LPN maintained aseptic technique.	G 182		
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the agency failed to ensure patient care instructions were complete for home health aides for 2 of 5 patients receiving home health aide services (#8 and #11) whose	G 224		

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G 224	Continued From page 33 records were reviewed. This had the potential to interfere with continuity and safety of patient care. Findings include: An agency policy, "Patient Care Plan," effective 3/98, stated all areas of the Care Plan must be filled out. The Care Plans were not completely filled out, as follows: 1. Patient #8 was a 78 year old patient who was admitted to the home health agency on 1/01/12 for care related to a leg injury, weakness, and pneumonia. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE (Form 485)" for certification period 12/16/11 to 2/14/12 indicated use of a walker or cane as a safety measure. A "Physician's Interim Order," dated 1/04/11, stated Patient #8 had impaired functional mobility due to decreased strength in the left leg. It also stated Patient #8 required stand by assistance with transfers, was able to walk short distances with a front wheeled walker and minimal assistance. It also stated he used a wheelchair for mobility in the home. The "Aide Care Plan," dated 1/05/12, did not provide the aide guidance related to ambulation or transferring Patient #8, such as whether to use a wheelchair, walker, cane, or gait belt. The Director of Professional Services was interviewed on 1/10/11 at 10:50 AM. She reviewed Patient #8's record and confirmed the specific guidance for the home health aide was missing on the care plan for the aide. The aide care plan was incomplete.	G 224	Tag: G224 Specific Action Taken: Nursing/Therapy Staff inservice related to detailed completion of home health aide care plan will be conducted by Director of Professional Services and Therapy Director. Systemic/Policy Adjustment: None needed Monitoring: Case manager or designee will review each home health aide care plan. All current home health aide plans of care will be reviewed for completeness. Date completed: March 15, 2012	

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G 224	Continued From page 34 2. Patient #11 was a 50 year old male who was admitted to the agency on 3/03/11 for care primarily related to diabetes. The Recertification Assessment, dated 10/25/11 at 2:00 PM, documented the following DME to be included on the Plan of Care: cane, grab bars, and tub/shower bench. The assessment documented the need for safety measures, including fall precautions, clear pathways, and walker/cane. The "Aide Care Plan," updated on 10/25/11, included guidance for the home health aide to assist Patient #11 with a shower. It did not document the need to use a cane, grab bars, or a tub/shower bench. The care plan did not identify the need for fall precautions. The Director of Professional Services was interviewed on 1/12/12 at 3:25 PM. She reviewed Patient #11's "Aide Care Plan" and confirmed the guidance was not included on the care plan. The aide care plan was incomplete.	G 224		
G 225	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. This STANDARD is not met as evidenced by: Based on record review, policy review, observation during a home visit, and staff interview, it was determined the agency failed to ensure home health aides provided services in accordance with aide plans of care for 2 of 5	G 225		

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CARE AT HOME	501 NORTH 16TH STREET, SUITE 112 PAYETTE, ID 83661

(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 225	Continued From page 35 patients receiving home health aide services (#11 and #12) whose records were reviewed. Findings include: An agency policy, "Certified Home Health Aide," effective 11/93, stated the home visits were to include providing personal care and assistance with ADL's following written assignment and guidelines. Aide assistance did not follow written assignments, per agency policy, as follows: 1. Patient #12 was a 68 year old male who was admitted to the agency on 10/28/11 for care related to Parkinson's disease and difficulty swallowing. A home visit was made on 1/12/11 between 11:10 AM and 11:45 AM to observe services provided to Patient #12 by a home health aide. During the visit, the home health aide was observed to offer to bring a manicure kit and trim Patient #12's fingernails the following visit. She explained to Patient #12 she did not feel comfortable trimming his toenails because they were too thick. She was also observed to offer to trim his beard the following visit. She told Patient #12 she was used to trimming her husband's beard and could do the same for him. The "Aide Care Plan," last updated 12/26/11, did not include guidance or approval for the home health aide to trim Patient #12's fingernails or beard. The Director of Professional Services was interviewed on 1/12/12 at 1:45 PM. When asked if the home health aide was allowed to trim nails and beard without the tasks being written on the aide care plan, she stated the home health aide's were supposed to follow the plan of care, not independently add or offer cares, even if the	G 225	Tag: G225 Specific Action Taken: The March inservice for all home health aides will educate and remind them to carefully follow all tasks written on each patient's care plan. Also, to make sure to never perform tasks that are not listed on the care plan without conferring with the case manager. Case managers will be instructed via inservice on proper completion of home health aide care plan and supervisory practices. Systemic/Policy Adjustment: None Needed Monitoring: Case manager or designee will perform a supervisory contact visit every two weeks. Date Completed: March 15, 2012	

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G 225	Continued From page 36 tasks were within their scope of practice. She confirmed the aide care plan did not include approval for these tasks. The home health aide offered cares not approved on the aide care plan. 2. Patient #11 was a 50 year old male who was admitted to the agency on 3/03/11 for care primarily related to diabetes. The "Aide Care Plan," last updated on 10/25/11, included the following handwritten instructions: * Check skin for red areas *Apply skin barrier to buttocks after cleansing each visit *Apply antiseptic to the fold of skin in buttocks after toileting or showering Home health aide visit notes did not document completion of the tasks listed above for visits on 11/01/11, 11/08/11, 11/22/11, 11/29/11, 12/07,11, 12/13/11. The same home health aide visit notes documented the aide removed or applied ace wraps. There was no instruction related to ace wraps on the "Aide Care Plan," last updated on 10/25/11. An aide visit note, dated 11/22/11, documented the aide "reminded to take/assisted with medications." This task was also not on the "Aide Care Plan." The Director of Professional Services was interviewed on 1/12/12 at 3:25 PM. She reviewed Patient #11's record. She stated the home health aides were never to assist with medications. She did not comment on the other findings. Home health aide services did not follow the	G 225		

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G 225	Continued From page 37 written care plan.	G 225		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on record review, policy review, patient interview, and staff interview, it was determined the agency failed to ensure comprehensive drug assessments were completed for 2 of 6 patients (#6 and #7) for whom home visits were completed. This resulted in an inability of the agency staff to fully assess medications for potential noncompliance with drug therapy, side effects, or ineffectiveness. Findings include: 1. Patient #6 was an 88 year old male who resided in an ALF and was admitted to the agency on 11/29/11 for care related to a wound that was not healing on his upper, left back. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 11/29/11 and untimed, for the certification period, 11/29/11 through 1/27/12, included, but was not limited to, the following medications: septra DS, Norco and Tylenol. The POC did not include an order for Combivent. A visit was conducted on 1/10/12, from 2:10 PM to 3:00 PM, with Patient #6 at the ALF. The RN was observed while she performed a dressing change and assessed Patient #6. A copy of Patient #6's medication record was obtained.	G 337	Tag: G337 Specific Action Taken: We have created a new work sheet that is included with the Start of Care packet to be utilized by the case manager upon review of the assessing professional's notes. It identifies additional information that must be included in the Plan of Care. It also helps to identify other disciplines that need to be contacted with information or referrals. It helps to clarify visit frequencies and any need for additional orders. This new procedure will ensure effective communication and coordination of care. The Director of Professional Services and the Therapy Director will inservice all professional staff regarding coordination of care and medication reconciliation. Evidence of inservice will be included in personnel files. New worksheet will help to identify allergies and ensure medication reviews are comprehensive and accurate. (Please see attached).	

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G 337	Continued From page 38 The medication record for the ALF included an order for Combivent, but failed to include orders for septra DS, Norco or Tylenol. The agency RN was interviewed on 1/12/12, from 1:00 PM to 1:25 PM. The RN reviewed the home health POC and medication list, as well as the medication record from the ALF. When asked to describe her process for medication review, she stated she completed a medication review at the SOC assessment and recertification assessment. The RN then stated she checked for new or changed medications during each visit. She agreed there were discrepancies between the home health medication list on the POC and the ALF medication record for Patient #6. The Director of Professional Services was interviewed on 1/12/12, from 3:10 PM to 3:20 PM. She reviewed Patient #6's medical record and the medication record from the ALF. The Director confirmed the discrepancies between the home health medication list and POC and the ALF medication record. She said the two should have been reconciled to reflect an accurate list of medications. The agency failed to ensure the medication reviews were comprehensive and accurate. 2. Patient #7 was a 67 year old woman who was admitted to the agency on 10/29/11 for aftercare following surgery to her left jaw area related to a neoplasm (abnormal mass of tissue or tumor.) The RN "Start or Resumption of Care" assessment, dated 11/26/11, from 1:00 PM to 2:30 PM, documented Patient #7 was allergic to sulfa and morphine. The "HOME HEALTH	G 337	Continued from page 38: Systemic/Policy Adjustment: Please see attached worksheet line medication reconciliation. Monitoring: Case manager or designee will review visit notes for medication or treatment changes. Date of completion: March 15, 2012	

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G 337	Continued From page 39 CERTIFICATION AND PLAN OF CARE," dated 10/29/11 and untimed, for the certification period, 12/28/11 through 2/25/12, ordered skilled nursing and physical therapy services and documented Patient #7 was allergic to morphine but failed to identify the allergy to sulfa. The 'Patient Medication List," dated 12/22/11 at 1.1:33 AM documented Patient #7 was allergic to codeine, morphine and sulfa. There was no documentation found to indicate which allergies were correct. The Director of Professional Services was interviewed on 1/12/12, from 2:50 PM to 3:05 PM. She reviewed Patient #7's record and confirmed there were discrepancies in the record related to Patient #7's list of allergies. She stated the list of allergies should have been clarified and corrected on the medication list and POC. An agency administrative policy, AP-15, on the subject of skilled nursing with an effective date of 11/93 documented the following : "Assessing the patient's present condition, including physical assessment, treatment needs, and current medications." The agency failed to ensure the medication reviews were comprehensive and accurate.	G 337		

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	OAS001080	A. BUILDING _____ B. WING _____	01/13/2012

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during a recent state licensure survey of your home health agency. The surveyors conducting the recertification were: Teresa Hamblin, RN, MS, HFS, Team Leader Rebecca Lara, RN, BA, HFS	N 000	RECEIVED FEB 15 2012 FACILITY STANDARDS	
N 002	03.07020.02. ADMIN.GOV.BODY N002 02. Structure. The administrative responsibilities of the agency shall be documented by means of a current organizational chart. This Rule is not met as evidenced by: Refer to G 123.	N 002	Tag: N 002 Please see response to tag G 123.	
N 050	03.07021. ADMINISTRATOR N050 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: d. Insuring that personnel employed shall be qualified to perform their assigned duties and that agency practices are supported by written personnel policies. This Rule is not met as evidenced by: Refer to G 141.	N 050	Tag: N 050 Please see response to tag G 141.	
N 051	03.07021. ADMINISTRATOR	N 051		

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N 051	Continued From page 1 N051 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: e. Personnel records of staff working directly with patients shall include: qualifications, licensure or certification when indicated, orientation to home health, the agency and its policies; performance evaluation, and documentation of attendance or participation in staff development, in-service, or continuing education; documentation of a current CPR certificate; and other safety measures mandated by state/federal rules or regulations. This Rule is not met as evidenced by: Refer to G 141.	N 051	Tag: N 051 Please see response to tag G 141.	
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G 143.	N 062	Tag: N 062 Please see response to tag G 143.	

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N 105	Continued From page 2	N 105		
N 105	03.07024. SK. NSG. SERV. N105 02. Licensed Practical Nurse. A licensed practical nurse perform the following: c. Prepares equipment and materials for treatments observing aseptic technique as required; This Rule is not met as evidenced by: Refer to G 182.	N 105	Tag: N 105 Please see response to tag G 182	
N 122	03.07024.SK.NSG.SERV. N122 05. Training, Assignment and Instruction of A Home Health Aide. c. Written instructions for home care, including specific exercises, are prepared by a registered nurse or therapist as appropriate. This Rule is not met as evidenced by: Refer to G 224.	N 122	Tag: N 122 Please see response to tag G 224	
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Refer to G 158.	N 152	Tag: N 152 Please see response to tag G 158	

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N 156	03.07030.PLAN OF CARE. N156 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: d. Frequency of visits; This Rule is not met as evidenced by: Refer to G 159.	N 156	Tag: N 156 Please see response to tag G 159	
N 172	03.07030.06.PLAN OF CARE N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This Rule is not met as evidenced by: Refer to G 164.	N 172	Tag: N 172 Please see response to tag G 164	
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any	N 173	Tag: N 173 Please see responses to tags G 165 and G 337	

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N 173	Continued From page 4 problems to the physician. This Rule is not met as evidenced by: Refer to G 165 and G 337.	N 173		
N 199	Criminal History and Background Check 009.CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS. 01. Compliance with Department ' s Criminal History and Background Check. A home health agency must comply with IDAPA 16.05.06, " Criminal History and Background Checks. " (3-26-08) 02. Direct Patient Access Individuals. These rules apply to employees and contractors hired or contracted with after October 1, 2007, who have direct patient access. (3-26-08) 03. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must complete an application before having access to patients. If a disqualifying crime as described in IDAPA 16.05.06, " Criminal History and Background Checks, " is disclosed, the individual cannot have access to any patient without a clearance by the Department. Once the notarized application is completed the individual can only work under supervision until the individual has been fingerprinted. The individual must have his fingerprints submitted to the Department within twenty-one (21) days of completion of the notarized application. (3-26-08) This Rule is not met as evidenced by: Based on review of personnel files and staff	N 199	Tag: N 199 Specific Action Taken: All current employee and contract files have been reviewed for criminal history and background check information. All new individuals hired or contracted will complete a criminal history background check application before having access to patients. If a disqualifying crime as described in IDAPA 16.05.06 is disclosed the individual will not have access to any patient without a clearance by the Department. The individual will only be allowed to work under supervision after the notarized application is completed until the individual has been fingerprinted. The individual will have fingerprints submitted to the Department within 21 days of completion of the notarized application. Systemic/Policy Adjustment: The above statement is our current policy. No changes were needed.	

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N 199	Continued From page 5 interview, it was determined the agency failed to ensure background checks were completed for 4 of 16 (Staff A, B, C, and D) staff whose personnel files were reviewed. This had the potential to allow employees who may have had disqualifying crimes access to patients. Findings include: 1. Staff A, a home health aide, was hired on 9/27/10. When reviewed on 1/10/12, a background check could not be found in her personnel file. The human resource staff person responsible for ensuring personnel files were complete was interviewed on 1/13/12, starting at 3:00 PM. She verified the file did not include evidence of a background check, however, stated the background check was in process. 2. Staff B, a home health aide, was hired on 3/03/11. When reviewed on 1/10/12, a background check could not be found in her personnel file. On 1/12/12, the Director of Nursing was provided a list of personnel files that did not appear to include completed background checks and asked to have the staff responsible review the files and flag any documents missed by the surveyor. When reviewed again on 1/13/12, a document was flagged in Staff B's file indicating it was the background check. The document included a print date of 1/13/12 and stated Staff B had passed a background check on 5/16/11. The human resource staff person responsible for ensuring personnel files were complete was interviewed on 1/13/12, starting at 3:00 PM. She verified Staff B's personnel file did not include evidence of a completed background check prior to 1/13/12. 3. Staff C, a speech therapist, was hired on 5/01/10. When reviewed on 1/10/12, a background check could not be found in her	N 199	Continued from page 5: Monitoring: The Human Resources Specialist will ensure that no newly hired or contracted individual will be allowed unsupervised access to patients until the above actions have taken place. The completed criminal history and background check will be filed in the personnel file. Date of Compliance: February 15, 2012	

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N 199	Continued From page 6 personnel file. On 1/12/12, the Director of Nursing was provided a list of personnel files that did not appear to include completed background checks and asked to have the staff responsible review the files and flag any documents missed by the surveyor. When reviewed again on 1/13/12, Staff C's file included a document printed on 1/13/12, showing Staff C had passed a background check on 10/13/10. The human resource staff responsible for ensuring personnel files were complete was interviewed on 1/13/12, starting at 3:00 PM. She verified Staff C's personnel file did not include evidence of a completed background check prior to 1/13/12. 4. Staff D, a physical therapist, was hired on 1/01/09. When reviewed on 1/10/12, a background check could not be found in her personnel file. On 1/12/12, the Director of Nursing was provided a list of personnel files that did not appear to include completed background checks and asked to have the staff responsible review the files and flag any documents missed by the surveyor. Staff D's personnel file was reviewed again on 1/13/12. The document showing a background check was in process was flagged with a note attached stating it was the background check. The human resource staff person responsible for ensuring personnel files were complete, interviewed on 1/13/12, starting at 3:00 PM, indicated the document was the background check. When pointed out that the document stated the background was in process, but did not verify completion, the human resource staff stated she would email Staff D to get evidence of the finalized background check. The agency did not ensure all direct service staff had completed a criminal history background check.	N 199		

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