IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

February 25, 2013

Kathryn Soady PT, Administrator
Gentiva Health Services CDA
1230 Northwood Center Ct, Ste C
Coeur D'Alene, Idaho 83814-4940

RE: Gentiva Health Services CDA, Provider #137112

Dear Ms. Soady:

This is to advise you of the findings of the Medicare/Licensure survey at Gentiva Health Services CDA, which was concluded on February 8, 2013.

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 agency into compliance, and that the agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567 and State Form 2567.

After you have completed your Plan of Correction, return the original to this office by **March 11, 2013**, 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,

SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137112	A. BUILDING _____ B. WING _____	02/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES CDA	1230 NORTHWOOD CENTER CT, STE C COEUR D'ALENE, ID 83814

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G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your agency. Surveyors conducting the recertification were: Susan Costa, RN, HFS, Team Leader Aimee Hastriter, RN, HFS Libby Doane, RN, HFS Acronyms used in this report include: COPD = Chronic Obstructive Pulmonary Disease CVP = Central Venous Pressure DME = Durable Medical Equipment ED = Emergency Department IV = Intravenous LPN = Licensed Practical Nurse mg = milligrams ml = milliliters MSW = Medical Social Worker O2 = Oxygen OT = Occupational Therapy PICC = Peripherally Inserted Central Catheter POT = Plan of Treatment PRN = As Needed PT = Physical Therapy PTA = Physical Therapy Assistant q = every RN = Registered Nurse SN = Skilled Nursing SOC = Start of Care Sub q = Subcutaneous (under the skin) UTI = Urinary Tract Infection	G 000		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange,	G 144		

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

Administrator | 03/09/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 144	Continued From page 1 reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records it was determined the agency failed to ensure care coordination between disciplines was documented for 5 of 10 patients (#3, #4, #6, #9 and #10) who received services from more than one discipline and whose records were reviewed. This had the potential to interfere with quality and continuity of patient care. Findings include: 1. Patient #9 was a 55 year old female whose SOC was 1/16/13. Her diagnoses included insulin dependent diabetes and recent total hip replacement. The POT included orders for SN, PT, OT and Social Worker services. Visit notes for Patient #9 from 1/06/13 to 2/05/13 were reviewed for documentation of coordination of care between the disciplines. There were 4 nursing visits and 10 therapy visits, none of the notes documented interdisciplinary care coordination. In an interview on 2/07/13 at 8:20 AM, the Physical Therapist who provided care for Patient #9 reviewed the record and confirmed he had not documented communication with the RN. In an interview on 2/07/13 at 10:20 AM, the RN who provided care for Patient #9 reviewed the record and confirmed the lack of documentation of coordination of care. The RN stated she communicated frequently with the therapist who	G 144	For patients #6 and #10, we were unable to correct due lack of supportive documentation and patients were no longer on service. For patient # 9, an interdisciplinary discharge case conference was held 02/11/2013 to ensure care coordination by all clinicians support the objectives of the plan of care and were addressed prior to discharge. Documentation of the interdisciplinary case conference was completed and filed in the clinical record by the Manager of Clinical Practice. For patients # 3 and #4, an interdisciplinary case conference was held 02/20/2013 to ensure care coordination by all clinicians support the objectives of the plan of care. Documentation of the interdisciplinary case conference was completed and filed in the clinical record by the Manager of Clinical Practice. Survey findings were reviewed with the specific clinicians involved in the care of these patients and with Managers of Clinical Practice.	

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G 144	Continued From page 2 worked with Patient #9, but had not documented those activities in the medical record. Coordination of care among personnel furnishing care to Patient #9 was not documented. 2. Patient #3 was a 69 year old male whose SOC was 1/04/13. His diagnoses included Type I diabetes with neuropathy and generalized muscle weakness. The POT included orders for SN, PT,OT and Social Worker services. Visit notes for Patient #3 from 1/04/13 to 1/28/13 were reviewed for documentation of coordination of care between the disciplines. There were 7 skilled nursing visits and 13 therapy visits, none of the notes documented interdisciplinary care coordination. In an interview on 2/07/13 beginning at 8:20 AM, the Physical Therapist who provided care for Patient #3 reviewed the record and confirmed he had not documented communication with the RN. In an interview on 2/07/13 beginning at 10:20 AM, the RN who provided care for Patient #3 reviewed the record and confirmed the lack of documentation of coordination of care. The RN stated she communicated frequently with the therapist who worked with Patient #3, but had not documented those activities in the medical record. Coordination of care among personnel furnishing care to Patient #3 was not documented. 3. Patient #6 was a 68 year old male whose SOC was 12/26/12. His diagnoses included infection	G 144	**Process change:** **Clinical staff will document in the visit notes communication regarding care that occurs between disciplines.** **Manager of Clinical Practice (or designee) will also document comprehensive interdisciplinary case conference summaries reflective of the care coordination discussed.** **Corrective Action:** **Education: The Administrator will in-service all clinical staff, including clinical supervisors, regarding performance expectations including federal and state regulation and company policy pertaining to documentation of care coordination of care between disciplines.** **Monitoring:** **10 interdisciplinary case charts per week will be audited by Managers of Clinical Practice (or designee), and will include verification of interdisciplinary care coordination in the visit notes and the case conference summaries. Once findings support100% results, audits will reduce to 5 charts x 4 weeks. So long as findings support 100 % results, ongoing monitoring will occur for all interdisciplinary quarterly chart audits selected x 2 quarters.** **Quarterly Clinical Record Review Committee will monitor results for trends and make recommendations for team and individual performance improvement action plans.**	03/20/2013 03/15/2013 03/15/2013

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G 144	Continued From page 3 in his spinal cord and heart, arthritis, muscle weakness and difficulty with mobility. The POT included orders for SN, PT and OT services. Visit notes for Patient #6 from 12/26/12 to 1/30/13 were reviewed for documentation of coordination of care between the disciplines. There were 14 skilled nursing visits and 7 therapy visits, none of the notes documented interdisciplinary care coordination. In an interview on 2/07/13 beginning at 8:20 AM, the Physical Therapist who provided care for Patient #6 reviewed the record and confirmed he had not documented communication with the RN. In an interview on 2/07/13 beginning at 10:20 AM, the RN who provided care for Patient #6 reviewed the record and confirmed the lack of documentation of coordination of care. The RN stated she communicated frequently with the therapist who worked with Patient #6, but had not documented those activities in the medical record. Coordination of care among personnel furnishing care to Patient #6 was not documented. 4. Patient #4 was an 82 year old male whose SOC was 1/11/13. His diagnoses included emphysema, COPD and diabetes. His POT for the certification period 1/11/13 through 3/11/13 was reviewed. The POT included orders for SN services, PT and OT. Visit notes for Patient #4 from 1/15/13 to 2/05/13 were reviewed for documentation of care between the disciplines. There were 7 PT visits,	G 144		

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G 144	Continued From page 4 3 OT visits, and 6 SN visits. There was no documentation of interdisciplinary communication. In an interview on 2/07/13 at 8:10 AM, the Physical Therapist who provided care for Patient #4 reviewed the record and confirmed there was no documentation of interdisciplinary coordination of care. The Physical Therapist stated he communicated frequently with the RN about Patient #4's care, but had not documented those activities in the medical record. In an interview on 2/07/13 at 9:15 AM, the RN who provided care for Patient #4 reviewed the record and confirmed there was no documentation of interdisciplinary coordination of care. The RN stated she communicated frequently with the therapist about Patient #4's care, but had not documented those activities in the medical record. Coordination of care among personnel furnishing care to Patient #4 was not documented. 5. Patient #10 was an 82 year old female whose SOC was 11/13/12. She received care for a urinary tract infection, muscle weakness, obesity, and a history of a fall. The POT for the certification period 11/13/12 through 1/11/13 contained orders for PT. On 12/03/12 the PTA documented that Patient #10's lower extremities were swollen and her shoes did not appear to fit correctly. The PTA documented notifying the physical therapist regarding this new development. On 12/11/12, an RN documented completion of a	G 144		

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G 144	Continued From page 5 comprehensive nursing assessment for Patient #10. Patient #10 received four additional nursing visits and on 1/07/13 the RN documented Patient #10 was discharged from nursing services. On the discharge assessment paperwork the RN noted the physical therapist was aware that nursing staff would no longer be providing services. Patient #10 received 10 PT visits between 12/11/12 and 1/07/13. There was no documentation of communication between nursing staff and PT until 1/07/13. Patient #10's Physical Therapist was interviewed on 2/07/13 at 8:10 AM. He reviewed Patient #10's record and explained that after the physical therapy assistant contacted him on 12/03/11, he in turn notified Patient #10's primary care provider. He stated the primary care provider agreed that home health nursing services were appropriate for Patient #10. The Physical Therapist also stated that he was concerned about Patient #10's medication management and had requested the RN address this issue as well as the lower leg edema. He confirmed that Patient #10's record did not contain documentation to support the communication between the therapy and the primary care provider or nursing staff. Coordination of care among personnel furnishing care to Patient #10 was not documented.	G 144		
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.	G 158		

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G 158	Continued From page 6 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure care followed a written plan of care established by a physician licensed to practice in the state of Idaho for 2 of 12 patients (#9 and #12) whose records were reviewed. This resulted in initial therapy orders obtained from an out-of-state physician. Findings include: During an interview on 2/04/13 at 1:30 PM, the Branch Director explained that the agency considered the written plan of care to include physician orders in addition to the POT. The original plan of care was not established by a physician licensed in the state of Idaho as follows: 1. Patient #9 was a 55 year old female who was admitted to the agency on 1/16/13 after being hospitalized following a total hip replacement. Patient #9's record documented a PT evaluation was performed on 1/16/13 and the therapist contacted the surgeon who had performed the hip replacement for therapy orders. The physician was not licensed in the state of Idaho. The POT for the certification period 1/16/13 through 3/16/13 was addressed to an Idaho physician but was unsigned as of 2/06/13. During an interview on 2/06/13 at 3:30 PM, the Branch Director confirmed the physician who approved the original therapy orders was not licensed in the state of Idaho. 2. Patient #12 was a 72 year old male admitted to the agency on 9/15/12 after being hospitalized	G 158		

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G 158	Continued From page 7 following a below the knee amputation of the right leg. Patient #12's record documented a PT evaluation completed on 9/15/12. The physical therapist documented contacting Patient #12's physician for therapy orders on 9/15/12. In addition, Patient #12's record documented an OT evaluation completed on 9/17/12. The occupational therapist documented contacting Patient #12's physician for OT orders on 9/17/12. The physician was not licensed in the state of Idaho. The POT for the certification period 9/15/12 through 11/13/12 was addressed to an Idaho physician and signed on 10/08/12. The Manager of Clinical Practice was interviewed on 2/08/13 at 8:50 AM. She confirmed the physician who approved the original therapy orders was not licensed in the state of Idaho. According to the 42 CFR 42 484.4, a physician is defined as "A doctor of medicine, osteopathy or podiatry legally authorized to practice medicine and surgery by the State in which such function or action is performed." A written plan of care was not established by a physician licensed to practice in the state of Idaho.	G 158	**For patient #9, patient had completed plan of care and was discharged from services. For patient # 12, patient was a closed account and there was no opportunity for correction. Office staff education regarding the requirement occurred immediately on the day of notice, 02/07/2013, and a comprehensive audit of any out of state physicians was completed the next day by the Care Team Coordinator. It was determined that no other patient's were affected at that time.** **Process Change:** **All patient orders which direct care delivered by the HHA, will only be accepted by physicians licensed to practice medicine in the state of Idaho.** **Corrective Action:** **Clinical team and sales support team will educate patients and referral sources, as necessary, regarding the regulation and the requirement that a physician licensed in the state of Idaho, must provide all orders for care provided by the HHA.** **Monitoring:** **The Care Team Coordinator will ensure each physician providing orders for home health will have license verification completed to ensure that an active Idaho license is held prior to the HHA accepting orders for care.**	02/07/2013
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on observation, interview and review of medical records and policies, it was determined the agency failed to ensure nursing services were	G 170		

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G 170	Continued From page 8 provided in accordance with the treatment plan for 3 of 10 sample patients (#6, #9, and #11) who received nursing care. Failure to follow the established treatment plan had the potential to result in negative patient outcomes. Findings include: A policy titled "CARE PLANNING," undated, noted "The registered nurse, therapist, or social worker will develop the patient's plan of care in conjunction with the patient, physician, and with other team members involved in the care. Care planning for each patient is individualized to address the patient's problems and needs, goals/outcomes, and specific care or services to be provided. Plans of care will be reviewed and revised as necessary to meet the changing needs of the patient in the most effective manner to achieve the desired outcomes." Nursing care for the following patients was not provided according to the POT: 1. Patient #6 was a 68-year-old male admitted to the agency on 12/26/12 following hospitalization for a bacterial infection that started in his spinal cord and had spread to his heart. He had a PICC in his left arm for IV antibiotics which were administered three times a day. Patient #6's medical record contained physician orders signed on 1/08/13 for nursing visits every Wednesday at 5:00 PM to obtain blood samples including specifically timed Vancomycin blood levels, to change the dressing over the PICC insertion site and instructions for self-administration of antibiotics. Dressing changes were not completed and blood	G 170	**For patient # 6 we were unable to correct due to lack of supportive documentation. The findings were reviewed with the clinician. The clinician attended infusion coverage and documentation in-service training and was provided corrective counseling. For patient # 9, we were unable to correct due to lack of supportive documentation. The findings were reviewed with the clinician. The clinician received corrective counseling. For patient # 11, we were unable to correct due to lack of supportive documentation. The findings were reviewed with the clinician. The clinicians received corrective counseling.** **Process Change:** **All skilled nursing infusion services will follow HHA established related policies and procedures including documentation of all services provided. Services provided will be consistent with the established plan of care. Nurses will report and document barriers to following the plan of care and review with the Manager of Clinical Practice and ordering physician, to ensure care plan revision when indicated.** **When patient specific vital sign parameters are established, the nurse will document each skilled nursing visit including assess / perform / instruct interventions, consistent with the established care plan and physician notification of reportable vital sign findings including any indicated/directed care plan changes.** **The nurse will verify that a qualified physician order exists prior to the delivery of any and all patient care.**	02/14/2013

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G 170	Continued From page 9 samples were not obtained as ordered. - On 1/09/13, twelve days from the last PICC dressing change completed on 12/28/12, Patient #6's record noted he had pain and swelling in his left arm. On 1/09/13 the RN documented contacting Patient #6's physician regarding the change in condition. The RN documented that it was determined Patient #6's PICC had infiltrated (defined as an inadvertent administration of a solution into the surrounding tissue, most often as a result of the leakage of solutions from the vein to the surrounding tissue spaces during intravenous administration). Patient #6's dressing was not changed every Wednesday as orderd. - Nursing visits were ordered to be completed every Wednesday at 5:00 PM. Nursing visits were documented from 2:00 PM to 2:25 PM on 1/02/13, from 10:21 AM to 11:45 AM on 1/09/13, from 4:15 PM to 4:45 PM on 1/23/13, and from 4:25 PM to 5:00 PM on 1/30/13. Nursing visits at these times did not allow for the specifically timed Vancomycin blood levels to be obtained. During an interview on 2/07/13 beginning at 9:30 AM, Patient #6's RN reviewed the record. The RN confirmed the PICC dressing changes had not been performed every 7 days as ordered on the POT. The RN stated the broad range of times for the Wednesday visits was because the patient changed dosing times of the Vancomycin. She confirmed the record did not contain information regarding what time Patient #6 administered the Vancomycin and there was no documentation that the time the blood sample was obtained was changed in order to	G 170	**Corrective Action:** **Education:** Manager of Clinical Practice will in-service all nursing staff, regarding performance expectations, including federal, state and company policy re Physician Orders, documentation of the home visit, infusion services and establishing the care plan - specifically abnormal patient vital sign findings. Disciplinary counseling will be provided by the RN clinical supervisor for nurse staff who provides care which does not comply with established infusion policy, physician orders, and fail to provide reportable patient findings to the physician. **Monitoring:** The Manager of Clinical Practice (or designee) will audit 100% infusion clinical notes, for clinical and documentation compliance, prior to filing in the medical record. Trends will be reported to the Clinical Record Review Committee and the Quality Advisory Committee, which in turn will provide recommendation for group vs. individual performance improvement action planning based upon trend results. Clinical record review will be conducted by clinical team members and managers of clinical practice, to verify documentation related to vital sign assessments and reportable findings communicated to the physician. 10 interdisciplinary case charts per week will be audited by Managers of Clinical Practice (or designee), and will include verification of interdisciplinary care coordination in the visit notes and the case	02/14/2013 03/15/2013 02/08/2013

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G 170	Continued From page 10 accomodate this. Nursing care was not provided in accordance with the POT. b. Patient #9 was a 55 year old female whose SOC was 1/16/13. Her diagnoses included insulin dependent diabetes and recent total hip replacement. Her POT for the certification period of 1/16/13 through 3/16/13 contained orders for nursing to "Perform/Instruct: Injections: Lovenox 40 mg Sub q every day [a blood thinning medication] ...Assess/Perform/Instruct: Use of electronic Glucose measuring device, Preparation/administration of insulin, Monitor glucometer recordings for variations & compliance...Measure O2 Saturation every visit." In addition, Patient #9's medical record contained an order for blood tests to be done on 1/18/13 to follow up on abnormal results identified on the blood test done on 1/15/13. Patient #9's record contained documentation of four nursing visit notes, dated 1/16/13, 1/18/13, 1/22/13, and 1/24/13. Nursing failed to provide care in accordance with the POT as follows: - On 1/16/13 during the SOC visit, the RN documented she obtained the blood sample necessary for the test ordered on 1/18/13. - No O2 saturation level was documented for the 1/18/13 nursing visit. The RN who cared for Patient #9 was interviewed on 2/07/13 beginning at 9:30 AM. She reviewed Patient #9's record and confirmed she did not obtain orders from Patient #9's physician to draw	G 170	conference summaries. Once findings support100% results, audits will reduce to 5 charts x 4 weeks. So long as findings support 100 % results, ongoing monitoring will occur for all interdisciplinary quarterly chart audits selected x 2 quarters. The Clinical Record Review Committee will report trends and make recommendation for group vs. individual performance improvement action plans.	

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	137112	A. BUILDING _____ B. WING _____	02/08/2013

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G 170	Continued From page 11 the lab work 2 days early. The RN stated she performed O2 saturation assessments as needed based on her judgment of the patient at the time of the visit. Nursing staff did not provide care in accordance with the POT. c. Patient #11 was a 57 year old female whose SOC was 12/30/11. Documentation during the recertification period of 12/24/12 through 02/21/13 was reviewed. The POT for this period contained orders for skilled nursing to measure O2 saturation at each visit and as needed for shortness of breath and report to the physician if O2 saturation was less than 90% on room air. The POT also contained orders for O2 to be administered via nasal cannula as needed. Nursing services were not provided in accordance with the POT as follows: - A "SKILLED NURSING CLINICAL NOTE" signed by an RN and dated 1/08/13 documented Patient #11's O2 saturation as 80% "on room air." There was no documentation to indicate Patient #11 had been placed on O2 as a result of this measurement. There was no documentation to indicate this result had been reported to the physician. - A "SKILLED NURSING CLINICAL NOTE" signed by an RN and dated 1/12/13 documented Patient #11's O2 saturation as 88% and "O2 turned on." The documentation was unclear as to whether the O2 saturation was measured with the O2 on or off. There was no documentation to indicate the RN reassessed Patient #11 or that this result had been reported to the physician.	G 170		

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G 170	Continued From page 12 - A "SKILLED NURSING CLINICAL NOTE" signed by an RN and dated 1/28/13 documented Patient #11's O2 saturation as 84%. There was no documentation to indicate Patient #11 had been placed on O2 as a result of this measurement. There was no documentation to indicate this result had been reported to the physician. The Branch Director reviewed the record and was interviewed on 2/07/13 beginning at 10:44 AM. She confirmed there was no documentation to indicate skilled nursing had reported oxygen saturation levels below 90% as ordered on the POT. Care was not provided in accordance with the POT.	G 170		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on review of medical records and staff interview it was determined the agency failed to ensure medical records clearly documented the	G 236		

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G 236	Continued From page 13 course of treatment for 3 of 12 patients (#4, #6, and #7) whose records were reviewed. The failure had the potential to result in incomplete information available to staff providing patient care. Findings include: 1. Patient #6 was a 68-year-old male admitted to the agency on 12/26/12 following hospitalization for a bacterial infection that started in his spinal cord and had spread to his heart. He had a PICC in his left arm for IV antibiotics. He was on Vancomycin by IV infusion at 6:00 AM and 6:00 PM. Nursing visits were conducted at times inconsistent with the Vancomycin dosing schedule as follows: - 12/27/12 from 2:18 PM to 3:43 PM, - 12/28/12 from 4:18 PM to 4:52 PM, - 12/29/12 from 2:43 PM to 3:41 PM, - 12/30/12 from 1:40 PM to 2:32 PM, - 12/31/12 from 1:57 PM to 2:56 PM, - 1/09/13 from 10:21 AM to 11:45 AM, - 1/17/13 from 10:32 AM to 11:28 AM, - 1/23/13 from 4:15 PM to 4:45 PM. During an interview on 2/07/13 beginning at 9:30 AM, Patient #6's RN reviewed the record and confirmed the times of the nursing visits. She stated Patient #6 had changed his antibiotic administration times, so the hours of the nursing visits were changed to accommodate his schedule. She confirmed the medical record did not contain documentation to support the medication administration times changing. The RN stated she did not contact the physician for clarification of the medication changes, or attempt	G 236	**In regards to patient # 6, we were unable to correct, since the patient was already discharged from services. The survey findings were reviewed with the nurse and corrective counseling was provided. The clinician attended infusion coverage and documentation in-service training and was provided corrective counseling.** **Patient #7 documentation was corrected to include a requested copy of the physician visit verifying the catheter was changed and a late entry by the nurse explaining the lack of documentation pertaining to the ordered catheter change.** **For patient #4, the "Medication Profile" in the home was corrected to reflect insulin dosing frequency of "morning and night" instead of "two times a day." The clinician received corrective counseling.** **Process Change:** **Nurse documentation will clearly reflect the course of treatment in accordance with the established care plan. Changes in care will be supported by documentation reflective of nurse assessment, MD communication, and care plan revision.**	02/13/2013

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G 236	Continued From page 14 to educate Patient #6 on the importance of consistent antibiotic dosing times. Patient #6's medical record did not contain clear and concise documentation of his medication administration times. 2. Patient #7 was a 65 year old male whose SOC date was 12/15/12. His diagnoses included a stage IV pressure ulcer, quadriplegia, osteomyelitis, COPD and hypertension. Patient #7's POT for the certification period of 12/15/12 through 2/12/13 included orders for care of an indwelling urinary catheter. Orders included skilled nursing to change the catheter every month and irrigate the catheter with 100-1000 ml of sterile saline. There was documentation on the "SKILLED NURSING CLINICAL NOTE" on 12/27/12 that Patient #7's catheter had been changed according to the POT for the month of December. Documentation on the "SKILLED NURSING CLINICAL NOTE" for 1/23/13 stated Patient #7 and his caretaker had received education on "prevention of UTI [secondary] to Foley catheter placement per SN instruction [and] educational handout..." There was no documentation to indicate a new catheter had been placed at this visit. Furthermore, there was no documentation to indicate Patient #7's catheter had been changed for the month of January. The RN who completed the 1/23/13 visit note was interviewed on 2/07/13 beginning at 9:15 AM. She reviewed the record and confirmed she provided the education to Patient #7 and his	G 236	**Corrective Action:** **Individual corrective action planning will be utilized to address clinician specific performance errors.** **Monitoring:** **Manager of Clinical Practice will review 10 charts per month to monitor documentation standards for clinicians on corrective action plans. Action plan goals will be achieved by March 30th and maintained for three months before documentation auditing will be suspended.**	03/15/2013 03/30/2013

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G 236	Continued From page 15 caregiver. She stated Patient #7 had his catheter changed at the physician's office during the month of January and therefore agency staff did not need to complete this task. She stated that when a situation like this occurs she usually included a notation in the chart, but had not in this case. She agreed this lead to a lack of clarity as to when the catheter had been changed. She confirmed there was no documentation in Patient #7's chart to indicate his catheter had been changed monthly in accordance with the POT. Documentation of skilled nursing procedures was unclear. 3. Patient #4 was a 82 year old male admitted to the agency on 1/11/13 with COPD, diabetes, high blood pressure and emphysema. The POT for certification period 1/13/13 through 3/13/13 was reviewed. The POT listed an order for insulin "HUMULIN 70/30 INJECT 18 U [units] 2 [times] DAILY." Additional instructions for administration of the insulin on the POT, under "SPECIAL PROCEDURES/HIGH TECH," documented the insulin was to be given every morning and night. A hand written "Medication Profile," completed by the RN on 1/11/13, documented "Humulin 70/30 inject 18u 2 [times] daily." Patient #4's RN reviewed the record and was interviewed on 2/07/13 beginning at 9:15 AM. She confirmed Patient #4 had a copy of the "Medication Profile" at home. She stated she documented the insulin as two times daily instead of every morning and night because Patient #4 had been diabetic for many years and knew how	G 236		

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G 236	Continued From page 16 and when to administer insulin. She stated that if Patient #4 had been a newly diagnosed diabetic, or if insulin was new to him, she would have documented to take the insulin every morning and night. She agreed that the documentation on the "Medication Profile" lead to a lack of clarity as to when the insulin should be given. The Branch Director reviewed the record and was interviewed at 3:15 PM on 2/07/13. She agreed that documenting the insulin to be given two times daily lacked clarity as to when the insulin should be given. She stated the expectation would be for the insulin to be documented on the "Medication Profile" to be taken every morning and night. Documentation of instructions for home medication was unclear.	G 236		
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, observations during home visits, staff interview and patient interview, it was determined the agency failed to ensure the drug review was comprehensive for 2 of 6 patients (#3 and #9) who were visited in their homes. Failure to obtain an accurate patient medication list or to evaluate the list for duplicative therapy, drug interactions,	G 337		

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G 337	Continued From page 17 or significant side effects had the potential to place patients at risk for adverse events or negative drug interactions. Findings include: The "ASSESSMENT" policy, revised 1/14/11, indicated "At the time of the initial assessment and each subsequent assessment, prescription, over-the-counter drugs, and herbals the patient is taking will be evaluated. All medications will be evaluated for adverse events, duplication of medication therapy, contraindications, and other medication effects. If the agency is administering the drugs, specific orders for administration and/or teaching patient or family administration of the medications will be included on the Plan of Treatment." A complete review of medications did not occur in the following examples: 1. Patient #9 was a 55 year old female who was admitted to the agency on 1/16/13 following discharge from a rehabilitation facility after a total hip replacement. A form titled, "Medication Profile," signed by the RN on 1/16/13, documented the medications Patient #9 was taking at the time of admission, and included: - Lovenox 40 mg injected daily, - Metformin 2000 mg orally daily, - Januvia 100 mg orally daily. Immediately after an observation of a Social Worker home visit on 2/06/13 at 11:30 AM, a review of medications was performed with Patient #9. Discrepancies were noted with the above	G 337	**For patient #9, the Medication Profile was updated to reflect accurate medication reconciliation. The nurse received corrective counseling and will complete drug reconciliation in-service training by March 30th. 2013.** **For patient # 3, the Medication Profile was updated to reflect accurate medication reconciliation. The nurse received corrective counseling and will complete drug reconciliation in-service training by March 30th. 2013.** **Process Change:** **Medication reconciliation will be performed, by all clinical staff, according to company policy and procedure at each time point assessment. Verification of any medication change will be verified and documented each visit, by all clinical staff.** **Medication administration performed by nursing staff will be in accordance with established physician orders and documented in the clinical visit note accordingly.** **Corrective Action:** **Education: All staff will complete the Gentiva University self paced workbook "Medication Reconciliation" for a review of company process and standards of documentation and maintaining the "Medication Profile" accuracy.**	03/30/2013 04/15/2013

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G 337	Continued From page 18 listed medications. Patient #9 stated the Lovenox injections were stopped before she left the hospital, and she had not received injections at home. In addition, Patient #9 stated she was taking Janumet 50/1000 twice daily rather than the Januvia and Metformin that was listed on the "Medication Profile." During an interview on 2/08/13 beginning at 9:30 AM, the RN reviewed Patient #9's record and initially stated she had administered three injections of Lovenox to Patient #9. When questioned regarding documentation of the three doses of Lovenox, the RN then stated she only administered one injection. She explained that the Lovenox was then discontinued by Patient #9's physician. She confirmed there was no physician order to discontinue the medication, and she had not completed documention to indicate the medication had ever been given. The RN stated she completed the "Medication Profile" after reviewing the list of medications Patient #9 had been taking at the hospital. She stated she was not consistent with medication review and asking about medication changes with her patients during routine visits. The medication list in Patient #9's medical record was not accurate and current on the date of the home visit. b. Patient #3 was a 69 year old male who was admitted to the agency on 1/04/13 following discharge from a rehabilitation facility after being treated for respiratory failure, diabetes, and septic shock. The POT for the certification period of 1/04/13 through 3/04/13 contained a list of medications including:	G 337	**Monitoring:** **4 random supervisory visits will be conducted each month by the Managers of Clinical Practice (or designee) and they will do medication reconciliation during the visit. Performance issues identified during the visit will result in review with the clinician, of findings with coaching and corrective counseling as indicated. Once 90% compliance is achieved, supervisory visits may be reduced to 4 per quarter to monitor medication reconciliation. Corrective counseling will be utilized for clinicians who persist in failing to follow policy for medication reconciliation and updates.** **Supervisory summaries of visits will be reported to the Quarterly Advisory Committee for trending and recommendation for team vs. individual performance improvement planning.**	04/30/2013

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G 337	Continued From page 19 - Depakote 125 mg take two by mouth daily, - Novolog 3 units in addition to a sliding scale dose 4 times daily, - Lantus 55 units every morning and 50 units every evening, - Gabapentin 600 mg twice daily. Immediately after an observation of a Home Health Aide home visit on 2/05/13 at 8:00 AM, a review of medications was performed with Patient #3. Discrepancies were noted in comparison to the medications listed on the POT. Patient #3's wife stated the Novolog 3 units plus sliding scale doses had been changed to Humalog 25 units plus the sliding scale doses. In addition, she stated her husband was taking Gabapentin 300 mg twice daily rather than the Gabapentin 600 mg twice daily. Patient #3's wife stated her husband was taking Lantus 50 units twice daily rather than 55 units in the morning and 50 units in the evening. Patient #3's wife stated he was taking Depakote 125 mg, two tablets three times a day rather than only once a day. Patient #3's wife confirmed that the medication changes had been made at the time of the discharge from the rehabilitation facility. During an interview on 2/07/13 beginning at 9:30 AM, the RN reviewed Patient #9's medical record. She stated the Gabapentin and the Depakote doses documented on the POT were "probably typos [typographical errors]." She stated she obtained the medication list from documentation provided by the rehabilitation facility. The RN stated she was not consistent with asking about medication changes with her patients during routine visits. She stated she had not verified the	G 337		

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G 337	Continued From page 20 POT for accuracy. The medication list in Patient #3's medical record was not accurate and current on the date of the home visit.	G 337		

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your agency. Surveyors conducting the recertification were: Susan Costa, RN, HFS, Team Leader Aimee Hastriter, RN, HFS Libby Doane, RN, HFS Acronyms used in this report include: COPD = Chronic Obstructive Pulmonary Disease CVP = Central Venous Pressure DME = Durable Medical Equipment ED = Emergency Department IV = Intravenous LPN = Licensed Practical Nurse mg = milligrams ml = milliliters MSW = Medical Social Worker O2 = Oxygen OT = Occupational Therapy PICC = Peripherally Inserted Central Catheter POT = Plan of Treatment PRN = As Needed PT = Physical Therapy PTA = Physical Therapy Assistant q = every RN = Registered Nurse SN = Skilled Nursing SOC = Start of Care Sub q = Subcutaneous (under the skin) UTI = Urinary Tract Infection	N 000		
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for:	N 062		

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N 062	Continued From page 1 i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G 144 as it relates to the agency's failure to ensure care coordination between disciplines was documented in the medical record.	N 062	See G 144	
N 091	03.07024. SK.NSG.SERV. N091. The HHA furnishes nursing services by or under the supervision of a registered nurse in accordance with the plan of care. This Rule is not met as evidenced by: Refer to G 170 as it relates to the agency's failure to ensure nursing services were provided in accordance with the treatment plan.	N 091	See G 170	
N 170	03.07030.04.PLAN OF CARE N170 04. Initial Plan of Care. The initial plan of care and subsequent changes to the plan of care are approved by a doctor of medicine, osteopathy, or podiatric medicine. This Rule is not met as evidenced by: Refer to G 158 as it relates to the agency's failure to ensure care followed a written plan of care established by a physician licensed to practice in the state of Idaho.	N 170	See G 158	

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N 173	Continued From page 2	N 173		
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 problems to the physician. This Rule is not met as evidenced by: Refer to G 337 as is relates to the agency's failure to ensure the drug review was comprehensive in order to identify side effects, drug allergies, or contraindicated medications.	N 173	See G 337	
N 174	03.07031.01 CLINICAL RECORDS N174 01. Purpose. A clinical record containing past and current findings, in accordance with accepted professional standards, is maintained for every patient receiving home health services. This Rule is not met as evidenced by: Refer to G 236 as it relates to the agency's failure to ensure medical records clearly documented the course of treatment.	N 174	See G 236	
N 199	Criminal History and Background Check	N 199		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001016	A. BUILDING _____ B. WING _____	02/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES CDA	1230 NORTHWOOD CENTER CT, STE C COEUR D'ALENE, ID 83814

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N 199	Continued From page 3 009.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 interview and review of personnel files, it was determined the facility failed to ensure criminal history and background checks were completed on 17 of 18 (Staff A, B, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, and R) staff members who had provided direct patient care. Failure to appropriately screen staff had the potential to negatively impact patient safety. Findings include:	N 199		

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N 199	Continued From page 4 Personnel files were reviewed for evidence of an Idaho Department of Health and Welfare background check. Only one file contained the appropriate background check paperwork. The following personnel files lacked qualifying background checks from the Idaho Department of Health and Welfare: Staff A- MSW hired 10/08/07 Staff B- LPN hired 7/27/12 Staff D- RN hired 1/31/11 Staff E- Home Health Aide hired 8/4/08 Staff F- Occupational Therapist hired 10/29/07 Staff G- LPN (hire date unknown) Staff H- RN hired 11/01/11 Staff I- Occupational Therapist hired 4/23/12 Staff J- Physical Therapist hired 4/12/12 Staff K- Physical Therapist (hire date unknown) Staff L- Speech Therapist (hire date unknown) Staff M- RN hired 2/27/12 Staff N- LPN hired 8/17/10 Staff O- RN (hire date unknown) Staff P- Physical Therapist hired 9/1/12 Staff Q- Physical Therapist hired 9/08/08 Staff R- Registered Dietician (hire date unknown) The Clinical Practice Manager was interviewed on 2/12/13 at 4:10 PM. She stated the agency was in the process of merging staff and patients with another local home health agency. She stated she did not know the specific date Staff G, K, L, O, and R began providing services for the agency. On 2/06/13 at 12:30 PM the Branch Director was asked to provide evidence of Idaho Department of Health & Welfare background checks for all agency employees with direct patient contact. She confirmed the agency had been completing	N 199	All identified staff, had established OIG/DHHS/GSA. OFAC, National Criminal and Felony, and Statewide criminal background checks prior to direct access to patient care delivery. Immediately upon notification of the state surveyor of the requirements of IDAPA 16.05.06 the Branch Administrator arranged for a notary and finger printer to be present on 02/07/13 and all staff, with the exception of 1 perdiem clinician, were assisted in completing the Idaho Department of Health Background Check Application form with notary signature, and received current fingerprint cards. All of these forms were immediately submitted to the state of Idaho Department of Health with fingerprint cards via United States Postal Service. The Branch Administrator received email confirmation of receipt and processing by the Department on 02/07/2013 that all online applications had been received and again on 2/18/2013 that the one remaining perdiem clinician had submitted the online application. Further email confirmation between the dates of 02/26/2013 and 03/01/2013 confirmed that the fingerprints and application had been received and the background check was in process. Will continue to monitor to ensure all final clearance letters are received from the Department.	

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N 199	Continued From page 5 background checks on employees but had not obtained a background check from the Idaho Department of Health & Welfare for the staff listed above. The facility did not ensure qualifying background checks were completed for all staff providing direct patient care.	N 199	**Process:** All new hires who will provide direct patient care will complete the Criminal History and Background Check application from the Idaho Department of Health before having access to patients. If a disqualifying crime as described in IDAPA 16.05.06 is disclosed the individual cannot have access to any patient without clearance by the Department. Once the notarized application is completed, the new hire will only work under supervision until fingerprinted. Fingerprints will be submitted to the Department within 21 days of the completion of the notarized application. **Correction:** The Agency WA specific policy regarding background check has been revised to more accurately reflect the Idaho home health criminal background check requirements through the Department of Health. **Monitoring:** The Administrator (or designee) will include the ID Department of Health Criminal Background Check application and clearance to the new hire chart audit check sheet and ensure each new hire is cleared by the Department prior to providing direct patient care without supervision.	02/08/2013 02/08/2013 02/08/2013