



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
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CERTIFIED MAIL: 7012 1010 0002 0836 1468

March 25, 2013

Julie Burnett, Administrator
Family Home Health
2950 East Magic View Dr, Ste 100
Meridian, ID 83642-6246

RE: Family Home Health, Provider #137079

Dear Ms. Burnett:

Based on the survey completed at Family Home Health, on March 11, 2013, by our staff, we have determined Family Home Health is out of compliance with the following Medicare Home Health Agency (HHA) **Conditions of Participation: 42 CFR 484.14 Organization, Services, and Administration; 42 CFR 484.16 Group of Professional Personnel; 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision; and 42 CFR 484.52 Evaluation of the Agency's Program.** To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Family Home Health, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

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

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;

Julie Burnett, Administrator
March 25, 2013
Page 2 of 2

- 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 each form.

Such corrections must be achieved and compliance verified by this office, before April 25, 2013. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than April 17, 2013.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **April 8, 2013.**

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

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

Enclosures

ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Kate Mitchell, CMS Region X Office

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2013
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NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 2950 EAST MAGIC VIEW DR, STE 100 MERIDIAN, ID 83642
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G 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification survey of your agency. Surveyors conducting the recertification were:</p> <p>Gary Guiles, RN, HFS, Team Leader Sylvia Creswell, LSW, HFS Susan Costa RN, HFS Libby Doane RN, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>CHF - Congestive Heart Failure CNA - Certified Nurses Assistant COPD - Chronic Obstructive Pulmonary Disease DCS - Director of Clinical Services ED - Emergency Department ESRD - End Stage Renal Disease HHA - Home Health Agency H&P - History and Physical IV - Intravenous LPN - Licensed Practical Nurse MO - Month OT - Occupational Therapy PT - Physical Therapy PAC - Professional Advisory Committee, the agency's group of professional personnel POT - Plan of Treatment PRN - As Needed RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care ST - speech therapy UTI - Urinary Tract Infection VAC - Vacuum</p>	G 000		
G 114	484.10(e)(1)(i-iii) PATIENT LIABILITY FOR PAYMENT	G 114		

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MAY 10 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Julie A. Burnett</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/8/13</i>
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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.

Refer to plan of correction dated 4/8/13

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G 114	<p>Continued From page 1</p> <p>Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to pay.</p> <p>This STANDARD is not met as evidenced by: Based on review of admission paperwork, staff interview, review of policies, and patient interview, it was determined the agency failed to ensure Medicare patients were informed in writing of the extent to which payment could be expected, and the charges the individual might have to pay, for 12 of 12 patients (#s 1-12) whose records were reviewed. This had the potential to interfere with patients'/caregivers' ability to make reasonable, informed decisions about financial matters related to the agency's care and treatment. Findings include:</p> <p>The Admission packet and each patient record contained a form, titled "ADMISSION TO HOME CARE." Section 4 of the form, titled "AUTHORIZATION FOR GOVERNMENT PROGRAM BENEFITS," stated "I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct. I request that payment of authorized benefits be made directly to Family Home Health. I understand I will receive written notice from Family Home Health if services are not authorized under Medicare or Medicaid. I</p>	G 114	<p><i>Refer to POC dated 4/8/13</i></p>	

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G 114	<p>Continued From page 2</p> <p>understand services are expected to be fully paid by Medicare/Medicaid or government program (except for any deductibles and co-payments)." The form did not state the charges for services that would not be covered by Medicare or the charges the individuals might have to pay.</p> <p>Patient records #1-12 were reviewed. They each contained the above referenced form without additional specific information.</p> <p>A visit was made to Patient #5's home on 3/05/11 from 11:00 AM to 12:30 PM. During the home visit, when asked what she expected to have to pay for home health services, she stated she did not know, that she did not recall being informed. She expressed feeling worried about the cost and not knowing what to expect.</p> <p>The undated policy "NOTIFICATION OF FINANCIAL RESPONSIBILITY AND NON-COVERAGE, HOME HEALTH AGENCY BENEFICIARY NOTICE (HHABN)," included, "All clients determined to be eligible for care and service by the agency will be informed verbally and in writing regarding any financial responsibility for care and any non-covered care or service."</p> <p>The Administrator was interviewed on 3/07/11 at 1:20 PM. When asked if the agency provided information in writing to Medicare patients about what they were expected to pay, she stated they informed Medicare patients verbally, but not in writing.</p> <p>The agency did not inform patients in writing of the extent to which payment could be expected</p>	G 114	<p><i>Refer to AOC dated 4/8/13</i></p>	

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G 114	Continued From page 3	G 114		
G 122	from Federally funded programs and the charges the individuals may have to pay. 484.14 ORGANIZATION, SERVICES & ADMINISTRATION This CONDITION is not met as evidenced by: Based on staff interview and review of medical records, agency policies, and meeting minutes, it was determined the agency's governing body failed to ensure it assumed responsibility for the agency's operation. This resulted in the inability of the agency to ensure vital functions were carried out and to ensure all Medicare Conditions of Participation were met. Findings include: 1. Refer to G130 as it relates to the failure of the governing body to arrange for a group of professional personnel to advise the agency and review the agency's program. 2. Refer to G132 as it relates to the failure of the governing body to provide oversight of the agency. 3. Refer to G133 as it relates to the failure of the governing body to ensure the administrator maintained ongoing liaison among the governing body and the group of professional personnel. 4. Refer to G144 as it relates to the agency's failure to document coordination of care efforts. 5. Refer to G151 as it relates to the failure of the governing body to ensure the Condition of	G 122	Refer to plan of correction dated 4/8/13. Compliance date 4/17/13 <i>Julie Burnett, Administrator</i> 4/8/13	

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G 122	Continued From page 4 Participation of Group of Professional Personnel and related standards were met. 6. Refer to G156 as it relates to the failure of the governing body to ensure the Condition of Participation of Acceptance of Patients, Plan of Care, and Medical Supervision, and related standards were met. 7. Refer to G 244 as it relates to the failure of the governing body to ensure the Condition of Participation of Evaluation of the Agency's Program and related standards were met.	G 122		
G 130	484.14(b) GOVERNING BODY The governing body arranges for professional advice as required under §484.16. This STANDARD is not met as evidenced by: Based on staff interview and review of administrative documents, it was determined the agency's governing body failed to arrange for a group of professional personnel to advise the agency and review the agency's program as required under 42 CFR Part 484.16. This limited the ability of the agency to utilize the expertise of staff and others to oversee its operations. Findings include: Meeting minutes, dated 1/25/12, stated the PAC had met on that date and approved policies. No documentation was present that the PAC met	G 130	<i>Refer to POC dated 4/8/13</i>	

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G 130	Continued From page 5 after that date or performed any service for the agency through 3/08/13. The Administrator was interviewed on 3/11/13 beginning at 1:30 PM. She confirmed no meeting minutes documented PAC activities after 1/25/12.	G 130		
G 132	484.14(b) GOVERNING BODY The governing body oversees the management and fiscal affairs of the agency. This STANDARD is not met as evidenced by: Based on staff interview and review of administrative documents, it was determined the agency's governing body failed to provide oversight of the agency. This resulted in a lack of direction to staff. Findings include: 1. Two meetings of the governing body were documented between 1/01/12 and 3/11/13. These were dated 7/23/12 and 1/07/13. The 7/23/12 meeting minutes documented personnel decisions including the appointment of the Administrator and the Director of Clinical Services. The minutes also documented a new business model and financial issues. The 1/07/13 meeting minutes documented a review of corporate bylaws, the budget, and contracts. The governing body "...reviewed the agency's policy and procedures and found them to be adequate and appropriate." Neither meeting minutes documented	G 132	<i>Refer to POC dated 4/8/13</i>	

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G 132	<p>Continued From page 6</p> <p>communication to or from the PAC or the appointment of its members. Neither meeting minutes documented an agency self evaluation or other quality improvement activities.</p> <p>The Administrator was interviewed on 3/14/13 beginning at 3:05 PM. She confirmed the lack of minutes documenting the involvement of the governing body with the PAC and quality activities.</p> <p>The governing body was not involved with the group of professional personnel or quality improvement activities.</p> <p>2. The governing body failed to appoint a group of professional personnel. The group was called the "PAC" at the agency and the terms are used interchangeably in this report. No documentation was present that the group of professional personnel had been appointed by the governing body.</p> <p>Meeting minutes stated the PAC had met on 1/25/12 and approved policies. No documentation was present that the PAC met after that date or performed any service for the agency through 3/08/13.</p> <p>The Administrator was interviewed on 3/11/13 beginning at 1:30 PM. She stated there was no documentation showing the composition of the PAC or when they were appointed. She confirmed no meeting minutes documented PAC activities after 1/25/12.</p> <p>The governing body did not ensure a group of professional personnel performed duties for the</p>	G 132	<p><i>Refer to POC dated 4/8/13</i></p>		

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G 132	Continued From page 7 agency. 3. The governing body failed to develop and implement systems to evaluate the agency's program. An evaluation of the agency's program was not documented. A plan to evaluate the agency's program was not documented. Also, there was no documentation that quarterly record reviews had been conducted in order to ascertain compliance with the agency's policies. The Administrator was interviewed on 3/11/13 beginning at 2:00 PM. She confirmed systems had not been developed to evaluate the agency's program.	G 132			
G 133	The governing body failed to implement systems to evaluate the agency. 484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff. This STANDARD is not met as evidenced by: Based on staff interview and review of administrative documents, it was determined the agency failed to ensure the administrator maintained ongoing liaison among the governing body and the group of professional personnel. This resulted in a lack of consultation to persons responsible for running the agency. Findings	G 133	<i>Refer to POC dated 4/8/13</i>		

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G 133	Continued From page 8 include: Meeting minutes, dated 1/25/12, stated the PAC had met on that date and approved policies. No documentation was present that the PAC met after that date or performed any service for the agency through 3/08/13. The Administrator was interviewed on 3/11/13 beginning at 1:30 PM. She confirmed no meeting minutes documented PAC activities after 1/25/12. She stated she could not provide evidence of the groups activities for the past year. She also stated she did not have evidence a PAC had been appointed by the governing body. The administrator was not able to maintain ongoing liaison between the governing body and the group of professional personnel.	G 133		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, 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 6 of 12 patients (#1, #4, #5, #10, #11 and #12) 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	G 144	<i>Refer to POC dated 4/8/13</i>	

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G 144	<p>Continued From page 9 include:</p> <p>1. Patient #11 was a 42 year old female admitted to the facility on 10/03/12 for an abdominal wound with wound vac following gastric bypass surgery. Her POT included orders for physical therapy and skilled nursing services. Her medical record for the certification period of 10/03/12 through 12/01/12 was reviewed and contained the following:</p> <ul style="list-style-type: none"> - A "MISSED VISIT" note, signed by the Physical Therapist on 10/10/12, stated Patient #11 cancelled her physical therapy visit that day because she had gone to the ED the night before and was diagnosed with a UTI. The note stated that Patient #11 did not feel well. There was no documentation on the note to indicate the physician or the RN Case Manager had been notified. - A "MISSED VISIT" note, signed by the Physical Therapist on 10/11/12, stated Patient #11 had canceled her physical therapy visit because she still was not feeling well due to the UTI. There was no documentation on the note to indicate the physician or the RN Case Manager had been notified. - A "THERAPY VISIT NOTE," signed by the PT on 10/15/12, stated Patient #11 had been complaining of nausea, especially after taking pain medication. The PT documented she had communicated with the RN Case Manager, but there was no documentation to indicate what had been discussed. There was no documentation to indicate the physician had been notified. 	G 144	<p><i>Refer to POC dated 4/18/13</i></p>	

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G 144	<p>Continued From page 10</p> <p>- A "THERAPY VISIT NOTE," signed by the PT on 10/18/12, stated Patient #11 continued to complain of nausea and expressed frustration that her nausea had not improved over time. There was no documentation to indicate the physician or the RN Case Manager had been notified.</p> <p>- A "THERAPY VISIT NOTE," signed by the PT on 10/18/12, stated Patient #11 had experienced "some separation" of her abdominal wound. There was no documentation to indicate the physician or the RN Case Manager had been notified.</p> <p>At the time of the survey, the PT was unavailable to interview. The RN Case Manager who cared for Patient #11 reviewed the record and was interviewed on 3/08/13 at 8:15 AM. He said he was not aware that Patient #11 had a UTI, nausea, or separation of her abdominal wound. He confirmed there was no documentation to indicate skilled nursing had been notified of these changes in condition. He confirmed there was no documentation to indicate these changes in condition were communicated to the physician.</p> <p>The DCS was interviewed on 3/08/13 at 11:50 AM and reviewed Patient #11's record. He confirmed there was no documentation to indicate the changes in condition were communicated to the physician or the RN Case Manager. He confirmed that the PT did not coordinate care with the physician and the RN Case Manager.</p> <p>The medical record did not contain documentation of coordination of care.</p>	G 144	<p><i>Refer to POC dated 4/8/13</i></p>	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
G 144	<p>Continued From page 11</p> <p>2. Patient #10's medical record documented a 62 year old male who was admitted for home health services on 10/27/12. He was discharged on 2/04/13. He was admitted for home health services from a skilled nursing facility where he was being treated for a punctured lung. He was initially admitted for occupational and physical therapy services.</p> <p>Patient #10 developed pneumonia shortly after admission and was admitted to the hospital on 11/01/12. Home health care was resumed on 11/05/12. Nursing services and social services were ordered at that time. No documentation was present that staff caring for Patient #10 communicated with each other to coordinate care following his release from the hospital.</p> <p>The Director of Clinical Services was interviewed on 3/08/13 beginning at 11:20 AM. He confirmed coordination of care was not documented for Patient #10.</p> <p>Staff did not document coordination of care for Patient #10.</p> <p>3. Patient #1 was a 76 year old male whose SOC was 10/06/12. His diagnoses included insulin dependent diabetes, recent total knee replacement, asthma and hypertension. The POT for the certification period of 10/06/12-12/04/12 included orders for PT and SN services. The POT indicated SN was ordered related to physician ordered lab work, and diabetes and hypertension management. In addition, the POT contained parameters for vital signs including blood pressure and orders to monitor Patient #1's blood glucose results.</p>	G 144	<p><i>Refer to ADC dated 4/8/13</i></p>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/11/2013
NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 2950 EAST MAGIC VIEW DR, STE 100 MERIDIAN, ID 83642		
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G 144	<p>Continued From page 12</p> <p>Skilled Nurse Visit Notes for 10/11/12 and 10/15/12 indicated an LPN provided care for Patient #1. The POT indicated the physician was to be notified if 1) Patient #1's systolic (top number) blood pressure was greater than 160 or less than 90, or 2) the dystolic blood pressure was greater than 90 or less than 50. On 10/15/12 Patient #1's blood pressure was documented as 200/94 which was above the parameter included on the POT. There was no documentation that the physician was notified of the elevated blood pressure. There was no indication of further follow-up by the LPN, either by communication with the RN case manager or the DCS. There was no evidence of communication with the PT.</p> <p>Patient #1's record indicated he was admitted to the hospital on 10/18/12 for treatment related to high blood pressure.</p> <p>In an interview with the RN Case Manager on 3/08/13 beginning at 9:00 AM, he reviewed Patient #1's record and confirmed that while he was on vacation at the time of the LPN visits, there was no evidence the LPN communicated the elevated blood pressure readings with other team members. The RN stated the LPN had seen Patient #1 on that date, and as the LPN was no longer employed at the agency, would not be available for interview or further clarification.</p> <p>Coordination of care among personnel furnishing care to Patient #1 was not documented.</p> <p>4. Patient #4 was a 86 year old female whose SOC was 1/07/12. Her diagnoses included pneumonia, abnormal gait, arthritis, and</p>	G 144	<p><i>Refer to PDC dated 4/8/13</i></p>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/11/2013
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G 144	<p>Continued From page 13</p> <p>generalized muscle weakness. The POT included orders for PT, OT, and Home Health Aide services.</p> <p>Visit notes for Patient #4 from 1/07/13 to 3/05/13 were reviewed for documentation of coordination of care between the disciplines. There were 6 occupational therapy visits and 15 physical therapy visits, none of the notes documented interdisciplinary care coordination.</p> <p>In an interview on 3/08/13 beginning at 9:40 AM, the Physical Therapist who provided care for Patient #4 reviewed the record and confirmed she had not documented communication with the OT. The PT stated she communicated frequently with the OT who worked with Patient #4, but had not documented those activities in the medical record.</p> <p>Coordination of care among personnel furnishing care to Patient #4 was not documented.</p> <p>5. Patient #12 was a 69 year old female whose SOC was 1/21/13. Her diagnoses included paralysis, pressure ulcer stage 2, and recent placement of a colostomy. The POT included orders for SN and PT services.</p> <p>Visit notes for Patient #12 from 1/21/13 to 3/05/13 were reviewed for documentation of coordination of care between the disciplines. There were 15 skilled nursing visits and 14 therapy visits, none of the notes documented interdisciplinary care coordination.</p> <p>In an interview on 3/07/13 beginning at 3:20 PM, the Physical Therapist who provided care for</p>	G 144	<p><i>Refer to POC dated 4/8/13</i></p>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2013
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NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 2950 EAST MAGIC VIEW DR, STE 100 MERIDIAN, ID 83642
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G 144	<p>Continued From page 14</p> <p>Patient #12 reviewed the record and confirmed he had not documented communication with the RN.</p> <p>In an interview on 3/07/13 beginning at 11:00 AM, the RN who provided care for Patient #12 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 #12, but had not documented those activities in the medical record.</p> <p>Coordination of care among personnel furnishing care to Patient #12 was not documented.</p> <p>6. Patient #5 was a 93 year old female whose SOC was 2/05/13. Her diagnoses included diabetes, hypertension, lumbar spinal stenosis, anemia, and gait abnormality. The POT included orders for SN, Social Worker, PT and Home Health Aide services.</p> <p>Visit notes for Patient #5 from 2/05/13 to 3/05/13 were reviewed for documentation of coordination of care between the disciplines. There were 6 skilled nursing visits and 6 therapy visits, none of the notes documented interdisciplinary care coordination.</p> <p>In an interview on 3/07/13 beginning at 3:20 PM, the Physical Therapist who provided care for Patient #5 reviewed the record and confirmed he had not documented communication with the RN.</p> <p>In an interview on 3/07/13 beginning at 9:00 AM, the RN who provided care for Patient #5 reviewed the record and confirmed the lack of</p>	G 144	<p><i>Refer to POC dated 4/8/13</i></p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/11/2013
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G 144	<p>Continued From page 15</p> <p>documentation of coordination of care. The RN stated he communicated frequently with the therapist who worked with Patient #5, but had not documented those activities in the medical record.</p> <p>Coordination of care among personnel furnishing care to Patient #5 was not documented.</p> <p>7. Case Conferences lacked coordination of care as follows:</p> <p>During an interview on 3/04/13 at 11:35 AM, the DCS stated coordination of care among disciplines took place during weekly case conferences and as needed. He stated case conference was attended by all clinical staff, including the RN Case Managers, PT, and PT aide. He stated contracted services usually did not attend. He stated coordination of care that happened outside of case conference was documented on the clinical note or on a separate communication note. He stated not all patients were discussed during case conference. He explained that generally only new patients and patients that were due for recertification or those to be discharged in the upcoming 2 weeks that were discussed.</p> <p>The facility's case conference was observed on 3/05/13 beginning at 8:35 AM. The case conference was attended by the social worker, RNs, the PT and PT aide, CNA's, the Administrator and the DCS. During the case conference, RN Case Managers discussed patients in their care that were approaching the end of the certification period. The Case Managers gave a small report on select patients</p>	G 144	<p><i>Refer to POC dated 4/8/13</i></p>	

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

PRINTED: 03/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2013
NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 2950 EAST MAGIC VIEW DR, STE 100 MERIDIAN, ID 83642	
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G 144	Continued From page 16 which included, but was not limited to, information regarding symptom management, overall progress, wound status and issues with family members. At times the PT or CNA would add information about the patient being discussed. There was, however, no coordination of care discussed among the disciplines. It was difficult to determine how the disciplines worked together to achieve patient goals from the observations of the information discussed in case conference. Meeting minutes from past case conferences were requested and reviewed on 3/11/13 beginning at 1:30 PM. The meeting minutes did not contain notes, but patient names with staff initials beside them. There was no indication of interdisciplinary interchange or coordination of activities occurred. In an interview on 3/08/13 at 11:35 AM, the DCS stated the facility did not document topics that had been discussed during case conference, including any coordination of care that may have taken place.	G 144		
G 151	484.16 GROUP OF PROFESSIONAL PERSONNEL This CONDITION is not met as evidenced by: Based on review of agency meeting minutes and staff interview, it was determined the agency failed to establish a group of professional personnel. This resulted in a lack of guidance and oversight of the agency's policies and practices. Findings include:	G 151	<i>Refer to plan of correction dated 4/8/13. Compliance date of 4/17/13. Julie Burnett, Administrator 4/8/13</i>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

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G 151	Continued From page 17 1. Refer to G152 as it relates to the agency's failure to appoint a group of professional personnel. 2. Refer to G153 as it relates to the agency's failure to ensure a group of professional personnel had reviewed the agency's policies on an annual basis. 3. Refer to G154 as it relates to the failure of the agency to ensure a group of professional personnel met frequently to advise the agency on professional issues and to participate in the evaluation of the agency's program. The cumulative effect of these negative systemic practices resulted a lack of professional oversight by required people.	G 151		
G 152	484.16 GROUP OF PROFESSIONAL PERSONNEL A group of professional personnel includes at least one physician and one registered nurse (preferably a public health nurse), and appropriate representation from other professional disciplines. This STANDARD is not met as evidenced by: Based on staff interview and review of administrative documents, it was determined the agency failed to ensure a group of professional personnel had been appointed which included at least one physician, one registered nurse, and appropriate representation from other professional disciplines. This limited the ability of	G 152	<i>Refer to POC dated 4/8/13</i>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

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G 152	Continued From page 18 the agency to utilize the expertise of staff and others to oversee its operations. Findings include: Meeting minutes, dated 1/25/12, stated the PAC had met on that date. The attendance record stated a physician and an RN had attended the meeting. No other disciplines were represented at the meeting. No documentation was present the personnel at the meeting had been formally appointed to the PAC. As of 3/12/13, no PAC meeting minutes were documented to show the committee had met or performed any duties since 1/25/12. The Administrator was interviewed on 3/11/13 beginning at 1:30 PM. She stated there was no documentation that stated the required personnel had been appointed to the PAC. She confirmed no meeting minutes were documented after 1/25/12. Evidence that a group of professional personnel had been appointed and had served the agency in the past year was not present.	G 152			
G 153	484.16 GROUP OF PROFESSIONAL PERSONNEL The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency.	G 153	<i>Refer to POC 4/2/13</i>		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

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G 153	<p>Continued From page 19</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of administrative documents, it was determined the agency failed to ensure a group of professional personnel had reviewed the agency's policies on an annual basis. In addition, the group did not include at least one member who was neither an owner nor an employee of the agency. This limited the input of persons charged with oversight of the agency. Findings include:</p> <p>Meeting minutes, dated 1/25/12, stated the PAC had met on that date. As of 3/12/13, no PAC meeting minutes were documented to show the committee had met or performed any duties since 1/25/12. Also, the attendance record for the 1/25/12 meeting did not include a person who was neither an owner nor an employee of the agency.</p> <p>The Administrator was interviewed on 3/11/13 beginning at 1:30 PM. She confirmed the PAC had not met to review the agency's policies since 1/25/12. She also confirmed that no documentation was present to show that at least one member of the PAC was neither an owner nor an employee of the agency.</p> <p>The agency's group of professional personnel had not reviewed the agency's policies annually and did not include at least one person who was neither an owner nor an employee of the agency.</p>	G 153	
G 154	<p>484.16(a) ADVISORY AND EVALUATION FUNCTION</p> <p>The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the</p>	G 154	<p><i>Refer to POC dated 4/8/13</i></p>

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/11/2013
NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 2950 EAST MAGIC VIEW DR, STE 100 MERIDIAN, ID 83642		
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G 154	Continued From page 20 agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program. This STANDARD is not met as evidenced by: Based on staff interview and review of administrative documents, it was determined the agency failed to ensure a group of professional personnel met frequently to advise the agency on professional issues and to participate in the evaluation of the agency's program. This prevented the group from providing input to the agency. Findings include: Meeting minutes, dated 1/25/12, stated the PAC had met on that date. The minutes did not document the PAC reviewed or discussed an evaluation of the agency's program. As of 3/12/13, no PAC meeting minutes were documented to show the committee had met since the 1/25/12 meeting. The Administrator was interviewed on 3/11/13 beginning at 1:30 PM. She confirmed the PAC had not met since 1/25/12. She also stated a formal evaluation of the agency's program had not been conducted. The agency's group of professional personnel had not met frequently to perform the required functions.	G 154			
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 156	<i>Refer to plan of correction dated 4/8/13. Compliance date 4/17/13. Julie Burnett, Administrator 4/8/13</i>		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

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G 156	Continued From page 21 This CONDITION is not met as evidenced by: Based on staff interview and review of medical records and agency policies, it was determined the agency failed to ensure POTs were completely developed, followed, and updated. These failures had the potential to result in unmet patient needs and negatively impact the continuity, safety, and quality of patient care. Findings include: 1. Refer to G158 as it relates to the failure of the agency to ensure care followed a physicians' written plan of care. 2. Refer to G159 as it relates to the failure of the agency to ensure the plan of care covered all pertinent information. 3. Refer to G164 as it relates to the failure of the agency to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the plan of care. 4. Refer to G165 as it relates to the failure of the agency to ensure physician orders were obtained/clarified prior to the provision of wound care The cumulative effect of these negative systemic practices impeded the ability of the agency to provide care of adequate quality.	G 156	<i>Refer to POC dated 4/8/13</i>	
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established	G 158	<i>Refer to POC dated 4/8/13</i>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2013
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G 158	<p>Continued From page 22 and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>This STANDARD is not met as evidenced by: Based on record review, review of policies, and staff interview, it was determined the agency failed to ensure care followed a physicians' written plan of care for 9 of 12 patients (#1, #2, #3, #4, #8, #9, #10, #11 and #12) whose records were reviewed. This resulted in unauthorized treatments as well as omissions of care and had the potential to result in unmet patient needs. Findings include:</p> <p>1. The undated policy, "PHYSICIAN'S PLAN OF TREATMENT/CHANGE ORDERS" included, "Physician's orders on the plan of treatment shall relate to the diagnosis and must be considered reasonable and necessary treatment for that diagnosis. ...The plan of treatment shall include but not be limited to: Specific discipline, frequency and duration of services..."</p> <p>Patient care was not provided as ordered on the physician ordered POT as follows:</p> <p>a. Patient #1 was a 76 year old male whose SOC was 10/06/12. His diagnoses included insulin dependent diabetes, recent total knee replacement, asthma and hypertension. The POT for the certification period 10/06/12 to 12/04/12 included orders for SN and PT services.</p> <p>The POT included orders for SN to observe/assess Patient #1's diabetes control and provide instruction regarding his diagnoses and medication management. Skilled Nursing Visit</p>	G 158	<i>Refer to POC dated 4/8/13</i>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2013
NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 2960 EAST MAGIC VIEW DR, STE 100 MERIDIAN, ID 83642	
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G 158	<p>Continued From page 23</p> <p>Notes for 10/06/12, 10/11/12, and 10/15/12 did not include documentation of blood glucose results necessary to assess and monitor Patient #1's diabetes. The visit notes did not include evidence of patient education regarding diabetes or disease management.</p> <p>The POT included orders for SN to observe/assess respiratory status and assess oxygen saturation every visit. The POT indicated the physician was to be notified if 1) Patient #1's systolic (top number) blood pressure was greater than 160 or less than 90, or 2) the diastolic blood pressure was greater than 90 or less than 50. Skilled Nursing Visit Notes on 10/15/12 documented Patient #1's blood pressure as 200/94. The visit note did not include evidence that nursing staff contacted the physician for the elevated blood pressure measurement.</p> <p>The RN Case Manager was interviewed on 3/08/13 beginning at 9:00 AM. He reviewed Patient #1's record and confirmed the above lack of documentation. He stated he was on vacation at the time of the incident. He also stated an LPN saw Patient #1 on 10/15/12, and as the LPN was no longer employed at the agency, was not available for interview.</p> <p>Patient #1's blood glucose and blood pressure were not fully assessed and responded to as directed by the POT.</p> <p>b. Patient #2 was a 94 year old female with hypertension and CHF who was admitted to the agency on 11/08/12 for care related to a stage 2 pressure ulcer on her buttocks. The POT for the certification period 1/07/13 to 3/07/13 included</p>	G 158	<p><i>Refer to POC dated 4/8/13</i></p>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2013
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NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 2950 EAST MAGIC VIEW DR, STE 100 MERIDIAN, ID 83642
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G 158	<p>Continued From page 24</p> <p>wound care orders for the stage 2 pressure ulcer on her buttocks as "Keep dry-do not apply occlusive dressing (one that seals the wound from contact with air or bacteria)."</p> <p>A Skilled Nursing Visit Note, dated 1/22/13, included documentation of wound care to Patient #2's left foot which included cleansing, application of skin prep and placement of Tegaderm (an occlusive dressing).</p> <p>A Skilled Nursing Visit Note, dated 1/25/13 included documentation of wound care to Patient #2's left foot. The note described the wound as a stage 2 pressure ulcer, with drainage and reddened skin surrounding the area.</p> <p>A Skilled Nursing Visit Note, dated 1/28/13, included documentation of wound care to Patient #2's left foot which included cleansing, placement of PolyMem (a dressing), skin prep and tape.</p> <p>A "PHYSICIAN FAX SHEET," signed and dated by the physician on 1/29/13, provided orders to cleanse the left foot wound, apply skin prep, place foam dressing over the wound and secure with tape. The wound care was ordered for two times weekly. The physician was not contacted for wound care orders until after the third nursing visit had been completed.</p> <p>The RN Case Manager for Patient #2 was interviewed on 3/08/13 beginning at 4:30 PM. After review of the record, the RN confirmed she had provided wound care to Patient #2's left foot before obtaining orders. The RN stated she had been instructed to provide the care and complete a "PHYSICIAN FAX SHEET" with the request for</p>	G 158	Refer to POC dated 4/8/13	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 2960 EAST MAGIC VIEW DR, STE 100 MERIDIAN, ID 83642		
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G 158	<p>Continued From page 26 orders. She stated she had not notified the physician or received verbal orders before providing the wound care.</p> <p>Wound care for Patient #2 was provided by the RN before physician orders were obtained.</p> <p>c. Patient #12 was a 69 year old female admitted to the agency on 1/21/13 for wound care and physical therapy.</p> <p>The POT for the certification period 1/21/13 to 3/21/13 included wound care orders which included wound cleansing, covering the wound with Mepilex foam (a type of dressing), and then securing with tape.</p> <p>Skilled Nursing Visit Notes, dated 1/30/13 and 2/01/13, included documentation that wound care for Patient #12 included administration of Ag gel (a silver antimicrobial gel) onto the wound bed in addition to the wound care that was detailed on the POT. There was no order for the Ag gel found in Patient #12's medical record.</p> <p>The RN Case Manager for Patient #12 was interviewed on 3/07/13 beginning at 11:00 AM. She reviewed Patient #12's record and confirmed wound care was provided using Ag gel. The RN stated Patient #12 had the wound dressing gel from when she had been in the hospital and had requested the gel be used. The RN confirmed she did not notify the physician for modification of wound care orders.</p> <p>d. Patient #8 was a 79 year old female admitted to the HHA on 2/7/13 for abdominal wounds, diabetes, COPD and high blood pressure. The</p>	G 158	Refer to POC dated 4/8/13	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 2950 EAST MAGIC VIEW DR, STE 100 MERIDIAN, ID 83642
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G 158	<p>Continued From page 26 POT included orders for SN services.</p> <p>The POT for the certification period 2/07/13 through 4/07/13 included orders for skilled nursing to assess oxygen saturation level every visit and to perform a blood glucose check during every visit.</p> <p>Skilled Nursing Visit Notes for 2/20/13 and 2/25/13 did not include an assessment of Patient #8's oxygen saturation level.</p> <p>A Skilled Nursing Visit Note for 2/20/13 indicated Patient #8's blood glucose was 150-299 the night prior to the visit. There was no documentation to indicate a blood glucose level had been obtained during the visit as ordered.</p> <p>The RN that documented these visit notes was unavailable to interview at the time of the survey. The DCS was interviewed on 3/08/13 at 11:50 AM. He confirmed the Skilled Nursing Visit Notes for 2/20/13 and 2/25/13 did not include an assessment of oxygen saturation level as ordered on the POT. He also confirmed these visit notes did not clearly document a blood glucose level obtained at the time of the visit in accordance with the POT.</p> <p>Patient #8's blood glucose and oxygen saturations were not assessed as directed by the POT.</p> <p>e. Patient #11 was a 42 year old female admitted to the HHA on 10/03/12 for an abdominal wound with wound vac following gastric bypass surgery.</p> <p>The POT for the certification period 10/03/12</p>	G 158	<p><i>Refer to POC dated 4/8/13</i></p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2013
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G 158	<p>Continued From page 27 through 12/01/12, signed by the physician on 11/05/12, documented the frequency of skilled nursing visits as twice a week for one week then three times a week for 8 weeks. During the visits skilled nursing was to perform dressing changes to the wound. The POT also ordered skilled nursing to measure the wound weekly.</p> <p>Skilled Nursing Visit Notes were reviewed from 10/03/12 through 11/16/12. The visit frequency followed the POT on the first week with two visits, one on 10/03/12 and one on 10/05/12. The second week of care, beginning 10/07/12 should have included three visits from skilled nursing. Only one Skilled Nursing Visit Notes, dated 10/08/12, was found.</p> <p>The RN Case Manager for Patient #11 reviewed the chart and was interviewed on 3/08/13 at 8:15 AM. He confirmed there should have been three skilled nursing visits during the week of 10/07/12. He confirmed there was only one skilled nursing visit note for that week. He stated that if the visits had been cancelled, it would be documented on a "MISSED VISIT" note. He confirmed there were no "MISSED VISIT" notes in the record for the week of 10/07/12. He confirmed there was no wound measurement documented for the week of 10/07/12 in accordance with the plan of care. He agreed that these missing visits lead to an incomplete record of the progression of Patient #11's wound.</p> <p>Skilled nursing did not provide services in accordance with the POT.</p> <p>f. Patient # 9 was a 63 year old male admitted to the HHA on 2/17/13 following a stay in a skilled</p>	G 158	<p><i>Refer to POC dated 4/8/13</i></p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2013
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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 2950 EAST MAGIC VIEW DR, STE 100 MERIDIAN, ID 83642		
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G 158	<p>Continued From page 28</p> <p>nursing facility after surgery on his left hip. His medical record for the certification period of 2/17/13 through 4/17/13 contained a document titled "TELEPHONE ORDERS" that was faxed from the skilled nursing facility included orders written on 2/13/13 at 10:30 AM that stated "May discharge home...Home Health RN PT OT..." The order was not signed by a physician. At the time of the survey, Patient #9's record documented he had received two skilled nursing visits and a physical therapy evaluation.</p> <p>The DCS reviewed the record and was interviewed on 3/08/13 at 10:40 AM. He stated that the HHA accepts orders from other facilities to start home health services as long as the orders were signed by a physician. He stated that because this order was not signed by a physician, it was invalid. He stated that the HHA should have clarified the order with the physician at the time it was received. He confirmed that there was no order for Patient #9 to begin home health services.</p> <p>The HHA accepted a patient for services, formed a POT, and provided services without an order.</p> <p>g. Patient #3's medical record documented a 67 year old female who was admitted for home health services on 11/20/12. She was currently a patient as of 3/04/13. According to her RN Case Manager, interviewed on 3/06/13 beginning at 8:55 AM, she had a failed total knee replacement in 2012 which later became infected. He stated she was completely bed bound. Current diagnoses included rheumatoid arthritis and depression.</p>	G 158	Refer to POC dated 4/18/13	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2013	
NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 2950 EAST MAGIC VIEW DR, STE 100 MERIDIAN, ID 83642		
(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 158	<p>Continued From page 29</p> <p>An order for social services to evaluate and treat Patient #3 was written on 2/08/13. The social service visit was not documented as of 3/06/13. No documentation was present in the record explaining why the social service visit had not been made.</p> <p>The Social Worker was interviewed on 3/06/13 beginning at 10:20 AM. She stated a social service visit had not been made in response to the 2/08/13 order.</p> <p>Patient #3's POT was not followed.</p> <p>h. Patient #10's medical record documented a 62 year old male who was admitted for home health services on 10/27/12. He was discharged on 2/04/13.</p> <p>Patient #10 was admitted for home health services from a skilled nursing facility. A "PHYSICIAN TELEPHONE ORDER," dated 10/25/12, stated "Home Health PT/OT/bath aide." The order was not signed by the physician nor was it signed by a nurse as of 3/06/13. It was not clear who wrote the order.</p> <p>The medical record documented the PT visited Patient #10 on 10/27/12 and provided services. Since the order to treat Patient #10 was not a valid order, the agency did not provide care in accordance with a written POT.</p> <p>The Director of Clinical Services was interviewed on 3/08/13 beginning at 10:40 AM. He confirmed an order to provide home health services to Patient #10 was not in place.</p>	G 158	<p><i>Refer to POC dated 4/18/13</i></p>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2013
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NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 2950 EAST MAGIC VIEW DR, STE 100 MERIDIAN, ID 83642
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G 158	<p>Continued From page 30</p> <p>The agency provided services to Patient #10 without orders.</p> <p>2. Patient #4's POT was not established by a physician licensed in the state of Idaho as follows:</p> <p>Patient #4 was a 86 year old female whose SOC was 1/07/12. Her diagnoses included Pneumonia, Abnormal gait, Arthritis, and generalized muscle weakness. The POT for the certification period 1/07/13 through 3/07/13 included orders for PT, OT, and Home Health Aide services.</p> <p>The physician was not licensed in the state of Idaho. The POT was addressed to an Oregon physician and had not been signed as of 3/07/13.</p> <p>The undated policy, "MEDICAL SUPERVISION" included, "The agency will accept orders for care from any physician of medicine, osteopathy or podiatry who is legally authorized to practice medicine in the state in which practicing. ...If the physician practices outside of the area, a local physician shall be obtained."</p> <p>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."</p> <p>During an interview on 3/08/13 at 4:00 PM, the DCS confirmed the physician who was documented as Patient #4's physician was not licensed in the state of Idaho.</p> <p>Care did not follow a POT established by a</p>	G 158	<p><i>Refer to POC dated 4/8/13</i></p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 2950 EAST MAGIC VIEW DR, STE 100 MERIDIAN, ID 83642	
(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 158	Continued From page 31	G 158	Refer to POC dated 4/8/13	
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, observation, patient and staff interview, it was determined the agency failed to ensure the plan of care included all pertinent information for 8 of 12 patients (#1, #2, #3, #5, #6, #9, #10, and #11) whose records were reviewed. This had the potential to interfere with continuity and completeness of patient care. Findings include: 1. Patient #11 was a 42 year old female admitted to the HHA on 10/03/12 for an abdominal wound with a wound vac following gastric bypass surgery. She was discharged from services on 11/21/12. The medical record for the certification period of 10/03/12 through 12/01/12 was reviewed and contained incomplete and unclear information related to Patient #11's diabetes as follows: - The POT included a diagnosis of diabetes but did not include interventions related to the	G 159		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2013
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---------------------------------------------------------------	---------------------------------------------------------------------------------------------------------

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--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

G 159	<p>Continued From page 32 management of diabetes or medications for the treatment of diabetes.</p> <p>- Skilled nursing notes from 10/03/12 through 11/16/12 were reviewed. There was no documentation in the skilled nursing notes of interventions related to diabetes.</p> <p>- A "Physical Therapy Assessment/Plan of Care" dated 10/08/12 stated Patient # 11 had a history of insulin dependent diabetes and that Patient #11 "is no longer diabetic."</p> <p>- An H&P, dictated by Patient #11's physician on 9/19/12, stated Patient #11 had a diagnosis of insulin dependent diabetes. The H&P also stated Patient #11 was taking an oral medication for diabetes in addition to insulin.</p> <p>The RN Case Manager for Patient #11 was interviewed on 3/08/13 at 8:15 AM. He stated he was unaware Patient #11 was diabetic. He confirmed he performed the SOC assessment for Patient #11, from which the POT was generated. He stated that when he does the SOC assessment, he does not ask every patient if they have a history of diabetes. He stated his practice was to review the H&P that is provided and ask questions based on the H&P. The RN reviewed the H&P and confirmed it stated Patient #11 was an insulin-dependent diabetic. He then stated that "a lot of time the H&P will be wrong and the patient has never even had some of this stuff." He confirmed the POT included diabetes as a diagnosis, but did not include interventions or medications related to diabetes. He confirmed that he reviews the POT before it is sent to the physician. He confirmed skilled nursing did not</p>	G 159	<p><i>Refer to POC dated 4/8/13</i></p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 159	<p>Continued From page 33</p> <p>perform any interventions related to diabetes for Patient #11.</p> <p>The DCS reviewed the record and was interviewed on 3/08/13 at 11:50 AM. He confirmed the H&P indicated Patient #11 had insulin dependent diabetes and stated there was no reason to assume this was in some way incorrect. He confirmed the POT included a diagnosis of diabetes yet there were no interventions on the POT related to diabetes.</p> <p>The POT did not include complete and clear information.</p> <p>2. Patient #9 was a 63 year old male who was admitted to the HHA on 2/17/13 for care after hip surgery. His medical record for the certification period 2/17/13 through 4/17/13 was reviewed and contained the following:</p> <p>The POT included a goal of "Patient's depression will be controlled with medication as evidenced by increased mood and no self harm times 4 weeks." There were no medications listed on the POT for depression.</p> <p>The RN Case Manager for Patient #9 reviewed the record and was interviewed on 3/07/13 at 8:40 AM. She stated that she included the goal related to depression after talking with Patient #9 and concluding he was depressed. She stated the wording of the goal was taken from a template that was given to her by the former Clinical Director and did not accurately reflect Patient #9's status. She confirmed Patient #9 was not on any medications to treat depression. She also stated Patient #9 had not verbalized</p>	G 159	<p><i>Refer to POC dated 4/8/13</i></p>	

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

PRINTED: 03/26/2013
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NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 2950 EAST MAGIC VIEW DR, STE 100 MERIDIAN, ID 83642
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G 159	<p>Continued From page 34</p> <p>ideation of harming himself. She agreed the POT was unclear as it pertained to a diagnosis of depression.</p> <p>The POT contained incorrect information regarding Patient #9's depression.</p> <p>3. Patient #6 was an 88 year old male whose SOC was 2/15/13. His diagnoses included edema, spinal stenosis and hypertension. The POT for the certification period 2/15/13 to 4/15/13 contained orders for SN frequency as "5mo1, 3mo2 + 2 PRN for Complications." The frequency was unclear as to when the nurse would see the patient.</p> <p>In an interview on 3/07/13 at 10:20 AM, the RN Case Manager reviewed Patient #6's medical record. She stated 5m1 indicated there would be 5 nursing visits in the first month of the certification period and 3mo2 meant 3 visits the second and third months. She stated it would be left to the nurse to decide when the 5 visits would occur in the first month, but that they were usually at least once a week.</p> <p>The SN and home health aide frequencies on the POT for Patient #6 were not specific.</p> <p>4. Patient #1 was a 76 year old male whose SOC was 10/06/12. His diagnoses included insulin dependent diabetes, recent total knee replacement, asthma and hypertension. The POT contained orders for SN frequency as 6mo1 and 0mo1. The frequency was unclear when the nurse would see the patient.</p> <p>In an interview on 3/08/13 beginning at 9:00 AM,</p>	G 159	<p><i>Refer to POC dated 4/2/13</i></p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/26/2013
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2013
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NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 2950 EAST MAGIC VIEW DR, STE 100 MERIDIAN, ID 83642
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G 159	<p>Continued From page 35</p> <p>the RN Case Manager reviewed Patient #5's medical record. He stated 5m1 indicated there would be 5 nursing visits in the first month of the certification period and no visits the second month. He stated it would be left to the nurse to decide when the 5 visits would occur in the first month.</p> <p>The POT nursing frequency for Patient #1 was not complete.</p> <p>5. Patient #2 was a 94 year old female with hypertension and CHF who was admitted to the agency on 11/08/12 for care related to a stage 2 pressure ulcer. The POT contained orders for SN frequency as "3mo1, 2mo1, +2 PRN for Catheter Complications." The frequency was unclear when the nurse would see the patient.</p> <p>In an interview on 3/08/13 beginning at 4:30 PM, the RN Case Manager reviewed Patient #2's medical record and stated the frequency listed on the POT indicated 3 visits during the first month of the certification period and 2 visits the second month.</p> <p>The POT did not include all pertinent information.</p> <p>6. Patient #5 was a 93 year old female with diabetes, hypertension, and unstable gait who was admitted to the agency on 2/05/13. The POT contained orders for SN frequency as "5m1, 4m1, +2 PRN for Falls." Home health aide order frequency was written as "1w1, 2w5, 1w1, 0w2. The frequency was unclear when the nurse or HHA would see the patient.</p> <p>In an interview on 3/08/13 beginning at 9:00 AM,</p>	G 159	<p><i>Refer to POC dated 4/8/13</i></p>	

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

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G 159	<p>Continued From page 36</p> <p>the RN Case Manager reviewed Patient #5's medical record. He stated 5m1 indicated there would be 5 nursing visits in the first month of the certification period. He stated it would be left to the nurse to decide when the 5 visits would occur. He confirmed the 0w2 frequency for the HHA would indicate no HHA visits for the last 2 weeks of the certification period.</p> <p>The POT did not include all pertinent information.</p> <p>7. Patient #3's medical record documented a 67 year old female who was admitted for home health services on 11/20/12. She was currently a patient as of 3/04/13. According to her RN Case Manager, interviewed on 3/06/13 beginning at 8:55 AM, she had a failed total knee replacement in 2012 which later became infected. He stated she was completely bed bound. Current diagnoses included rheumatoid arthritis and depression. The "START OF CARE ASSESSMENT," dated 11/20/12, stated Patient #3 had a portacath, a device implanted under the skin to administer intravenous solutions. Patient #3's POT dated 11/20/12, did not mention the portacath. Patient #3's medications listed on the POT included normal saline IV and Heparin solution IV but there were no directions to staff on when to flush the portacath or otherwise care for it.</p> <p>Patient #3's RN Case Manager was interviewed on 3/06/13 beginning at 8:55 AM. He confirmed the portacath was not addressed on the POT.</p> <p>Also, Patient #3's POT, dated 11/20/12, stated the nurse was to visit "6mo1, 2mo1." The plan did not explain how these visits were to be</p>	G 159	<i>Refer to POC dated 4/8/13</i>	

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

PRINTED: 03/26/2013
FORM APPROVED
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G 159	Continued From page 37 distributed though out the month. For example, was the nurse to conduct the visits at the first of the service month or the end or were they to somehow be distributed through the entire month. Patient #3's RN Case Manager was interviewed on 3/06/13 beginning at 8:55 AM. He confirmed the POT lacked clarity. Patient #3's POT did not include all required information. 8. Patient #10's medical record documented a 62 year old male who was admitted for home health services on 10/27/12. He was discharged on 2/04/13. He was admitted for home health services from a skilled nursing facility where he was being treated for a punctured lung. He was initially admitted for therapy services. Patient #10 developed pneumonia shortly after admission and was admitted to the hospital on 11/01/12. Home health care was resumed on 11/05/12. Nursing services were ordered at that time. A "RESUMPTION OF CARE ASSESSMENT" was completed by the RN on 11/06/12. Recommendations for the nursing POT were listed at the end of the assessment. However, a nursing POT was not documented. Patient #10's RN Case Manager was interviewed on 3/06/13 beginning at 11:45 AM. She stated confirmed the POT for Patient #10 had not been developed. Patient #10's POT did not include skilled nursing services as ordered.	G 159	<i>Refer to POC dated 4/8/13</i>		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF	G 164			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

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G 164	<p>Continued From page 38 CARE</p> <p>Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records and policies, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the plan of care for 4 of 12 patients (#1, #8, #11, and #12) whose records were reviewed. This resulted in missed opportunity for physicians to alter the plan of care to meet patient needs. Findings include:</p> <p>The undated policy "PHYSICIAN'S PLAN OF TREATMENT/CHANGE ORDERS" included "The physician's plan of treatment (Medicare's Plan of Care) is... based upon the current assessment of the client. ...The physician shall be notified immediately of any changes in the client's condition which indicate changes to the plan of treatment." This policy was not followed. Examples include:</p> <p>1. Patient #11 was a 42 year old female admitted to the HHA on 10/03/12 for an abdominal wound with a wound vac following gastric bypass surgery. Her medical record for the certification period of 10/03/12 through 12/01/12 was reviewed. The following changes in condition were noted:</p> <p>- A "MISSED VISIT" note, signed by the physical</p>	G 164	Refer to PDC dated 4/8/13	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

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G 164	<p>Continued From page 39</p> <p>therapist on 10/10/12, stated Patient #11 cancelled her physical therapy visit that day because she had gone to the ED the night before and was diagnosed with a UTI. The note stated that Patient #11 did not feel well. There was no documentation on the note to indicate the physician had been notified.</p> <p>- A "MISSED VISIT" note, signed by the physical therapist on 10/11/12, stated Patient #11 had cancelled her physical therapy visit because she still was not feeling well due to the UTI. There was no documentation on the note to indicate the physician had been notified.</p> <p>- A "THERAPY VISIT NOTE," signed by the physical therapist on 10/15/12, stated Patient #11 went to the ED on 10/09/12 and diagnosed with a UTI. The note also stated Patient #11 had been complaining of nausea, especially after taking pain medication. The physical therapist documented she had communicated with the RN Case Manager but there was no documentation to indicate the physician had been notified.</p> <p>- A "THERAPY VISIT NOTE," signed by the physical therapist on 10/18/12, stated Patient #11 continued to complain of nausea and expressed frustration that her nausea had not improved over time. There was no documentation to indicate the physician had been notified.</p> <p>- A "THERAPY VISIT NOTE," signed by the physical therapist on 10/18/12, stated Patient #11 had experienced "some separation" of her abdominal wound. There was no documentation to indicate the physician had been notified.</p>	G 164	Refer to POC dated 4/8/13	

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

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FORM APPROVED
OMB NO. 0938-0391

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G 164	<p>Continued From page 40</p> <p>At the time of the survey, the PT was unavailable to interview. The RN Case Manager who cared for Patient #11 reviewed the record and was interviewed on 3/08/13 at 8:15 AM. He said he was not aware that Patient #11 had a UTI, nausea, or separation of her abdominal wound. He stated that per agency policy, the physical therapist should have notified the physician and himself of these changes. He confirmed there was no documentation to indicate these changes in condition were communicated to the physician.</p> <p>The DCS reviewed the record and was interviewed on 3/08/13 at 11:50 AM. He confirmed there was no documentation to indicate these changes in condition were communicated to the physician. He confirmed that the PT failed to follow agency policy of notifying the physician of changes in condition. He agreed that this lead to missed opportunity for the physician to alter Patient #11's care.</p> <p>Patient #11's physician was not notified of changes in her condition.</p> <p>2. Patient #8 was a 79 year old female admitted to the HHA for abdominal wounds with a yeast infection, cellulitis, diabetes and high blood pressure. Her medical record for the certification period of 2/07/13 through 4/07/13 was reviewed.</p> <p>A "Skilled Nursing Visit Note," signed by an RN on 2/25/13, indicated a new "area of redness" had been noted beneath Patient #8's left breast. The RN documented she treated this wound in the same fashion as the abdominal wounds. There was no documentation to indicate the physician had been notified of the new wound.</p>	G 164	<p><i>Refer to PDC dated 4/8/13</i></p>	

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

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G 164	<p>Continued From page 41</p> <p>A "Skilled Nursing Visit Note," signed by the RN Case Manager on 2/22/13, indicated a "new area" on the left abdomen under the pannus. There was no documentation to indicate the physician had been notified of the new wound.</p> <p>The RN Case Manger reviewed the record and was interviewed on 3/08/13 at 9:10 AM. She stated the "new area" was a continuation of the original rash so she did not notify the physician of this. She stated that if the area had developed into a new "deeper" wound she would have called the physician. She also stated, however, that it was best practice to notify the physician of any changes in condition and the physician should have been notified of the new area of rash.</p> <p>Patient #8's physician was not notified of changes in her condition.</p> <p>3. Patient #1 was a 76 year old male whose SOC was 10/06/12. His diagnoses included insulin dependent diabetes, recent total knee replacement, asthma and hypertension. The POT included orders for SN and PT services.</p> <p>Patient #1's medical record was reviewed. A RN visit note, dated 10/15/12, documented Patient #1's blood pressure as 200/99. The POT included vital sign parameters with which to notify the physician. There was no documentation the physician had been alerted to Patient #1's elevated blood pressure. Patient #1 was admitted to the hospital 6 days later for treatment related to hypertension.</p> <p>The RN Case Manager was interviewed on</p>	G 164	<p><i>Refer to POC dated 4/8/13</i></p>	

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

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G 164	<p>Continued From page 42</p> <p>3/08/13 at 9:00 AM. He reviewed Patient #1's record and confirmed the physician had not been notified of the elevated blood pressure. He stated he was on vacation when the incident occurred. He stated an LPN had provided care on that day and he had not been alerted of Patient #1's blood pressure.</p> <p>Patient #1's medical record indicated he was admitted to the hospital on 10/18/12 for treatment related to high blood pressure.</p> <p>The physician for Patient #1 was not alerted related to his elevated blood pressure.</p> <p>4. Patient #12 was a 69 year old female who was admitted to the agency on 1/21/13 with diagnoses that included osteomyelitis, decubitus, paraplegia, and a stage 2 pressure ulcer. The POT for the certification period 1/21/13 to 3/21/13, included wound care orders as follows: "...wound care as ordered every visit until healed: cleanse with wound cleanser, cover with Meplex and secure with tape."</p> <p>On the "START OF CARE ASSESSMENT" form, dated 1/21/13, the RN documented Patient #12's wound at the time of admission as a pressure wound along the surgical flap repair over a healed decubitus ulcer on her right hip area. "Skilled Nursing Visit Note," dated 2/25/13, noted the decubitus was healed, and there was a new area of focus on Patient #12's left buttock. The RN documented a calloused area that had redness in the surrounding area. The note documented the area was cleansed well and would be watched carefully. On 2/27/13, the RN noted she provided wound care to Patient #12's left posterior hip by</p>	G 164	<p><i>Refer to POC dated 4/8/13</i></p>	

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

PRINTED: 03/26/2013
FORM APPROVED
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G 164	Continued From page 43 cleansing and padded it with foam. There was no documentation the physician had been alerted to Patient #12's newly identified wound. The RN Case Manager was interviewed on 3/08/13 at 2:05 PM. She reviewed Patient #12's record and confirmed the physician had not been notified of the new wound. The RN Case Manager stated she had applied a dressing to the wound to determine if there was drainage, and when she saw there was, she alerted the physician on 3/04/13. The RN Case Manager stated she phoned Patient #12's physician on 3/04/13 to obtain a referral for Patient #12 to go to the wound clinic for evaluation of the wound.	G 164	<i>Refer to POC dated 4/8/13</i>	
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 record review and staff interview it was determined the agency failed to ensure physician orders were obtained/clarified prior to the provision of wound care for 2 of 12 patients (#2 and #12) whose records were reviewed. This resulted in unauthorized medication administration and wound care and had the potential to negatively impact patient safety. Findings include:	G 165	<i>Refer to POC dated 4/8/13</i>	

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

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G 165	<p>Continued From page 44</p> <p>1. Patient #12 was a 69 year old female admitted to the agency on 1/21/13 for wound care and physical therapy.</p> <p>-The POT for the certification period 1/21/13 to 3/21/13 included wound care orders which included wound cleansing, covering the wound with Meplex foam, and then securing with tape.</p> <p>Skilled Nursing Visit Notes, dated 1/30/13 and 2/01/13, included documentation for the wound care for Patient #12 included administration of Ag gel (a silver antimicrobial gel) onto the wound bed in addition to the wound care that was detailed on the POT. There was no order for the Ag gel.</p> <p>The RN Case Manager for Patient #12 was interviewed on 3/07/13 beginning at 11:00 AM. She reviewed Patient #12's record and confirmed wound care had been provided using Ag gel. The RN stated Patient #12 had the wound dressing gel from when she had been in the hospital, and had requested the gel be used. The RN confirmed she did not notify the physician for clarification or approval before using the additional medication.</p> <p>Medication used in wound care was administered without physician orders.</p> <p>2. Patient #2 was a 94 year old female admitted to the agency on 11/08/12 for wound care and physical therapy.</p> <p>-The POT for the certification period 1/07/13 to 3/07/13 included wound care orders for a stage 2 pressure ulcer on her buttock. There was no</p>	G 165	Refer to POC dated 4/8/13	

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

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G 165	<p>Continued From page 45 indication Patient #2 had a wound on her foot.</p> <p>Skilled Nursing Visit notes documented wound care was administered for a left foot wound. There were no orders for wound care for the foot wound before the care was initiated as follows:</p> <ul style="list-style-type: none"> - Skilled Nursing Visit notes, dated 1/22/13 documented: "wound care to L(left) foot. Wound cleansed with Dermaklenz, Tegaderm applied (after) skin prep on peri wound. Wound bed red (with) small amount of serosanguinous drainage noted." - Skilled Nursing Visit notes, dated 1/25/13 documented: "wound on (left) lower extremity stage 2 (with) 2+ pitting edema on foot halfway up calf. Serous drainage noted, wound bed red." -Skilled Nursing Visit notes, dated 1/28/13 documented: "Tegaderm removed from LLE (left lower extremity). Wound measured using E-Z Graph Wound Assessment Worksheet. Wound bed red (with) some granulation, peri wound erythema and edema. Wound cleansed (with) DermaKlenz, Polymem to wound bed (after) skin prep used on peri wound, Bio fix tape. Wound on LLE (with) small amount of slightly cloudy tan secretions." <p>A "PHYSICIAN FAX SHEET," dated 1/28/13 contained a faxed communication to Patient #2's physician informing him of a wound on her left foot. The communication included a description of the appearance, drainage, and description of the wound care provided. The sheet contained a physician signature dated 1/29/13.</p>	G 165	Refer to POC dated 4/2/13	

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

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 2950 EAST MAGIC VIEW DR, STE 100 MERIDIAN, ID 83642		
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G 165	Continued From page 46 The RN Case Manager was interviewed on 3/08/13 beginning at 4:30 PM. She reviewed Patient #2's record and confirmed wound care had been administered before obtaining a physician order. The RN stated she had been instructed to provide wound care for the patient and then submit a request to the physician in the form of the Physician Fax Sheet. She stated after reviewing the request the physician would sign it and result in an order.	G 165	<i>Refer to PDC dated 4/2/13</i>	
G 228	484.36(d)(1) SUPERVISION If the patient receives skilled nursing care, the registered nurse must perform the supervisory visit required by paragraph (d)(2) of this section. If the patient is not receiving skilled nursing care, but is receiving another skilled service (that is, physical therapy, occupational therapy, or speech-language pathology services), supervision may be provided by the appropriate therapist. This STANDARD is not met as evidenced by: Based on review of clinical records and agency policies and staff interview, it was determined the agency failed to ensure that licensed staff made supervisory visits to the patient's home no less frequently than every 2 weeks for 1 of 6 sample patients (Patient #4) who received home health aide services. This prevented the agency from ensuring home health aides provided safe and effective care to patients. Findings include:	G 228	<i>Refer to PDC dated 4/8/13</i>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/11/2013
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G 228	<p>Continued From page 47</p> <p>Patient #4 was an 86 year old female whose SOC was 1/07/12. Her diagnoses included Pneumonia, Abnormal gait, Arthritis, and generalized muscle weakness. The POT for the certification period 1/08/13 to 3/08/13 included orders for PT, OT, and home health aide services.</p> <p>The "Home Health Aide Plan of Care" was completed by the admitting PT on 1/08/13. The PT instructed the home health aide to assist with shower care, hair care, and apply lotion with each visit. The POC was signed by the PT on 1/08/13 and cosigned by the home health aide on 1/14/13.</p> <p>The undated policy "SUPERVISION AND EVALUATION OF STAFF" included, "A registered nurse or therapist will make a supervisory visit to all clients receiving home health aide services at least every 2 weeks." Documentation of 2 week supervisory visits by the PT was not found in Patient #4's record.</p> <p>In an interview on 3/07/13 beginning at 9:15 AM, the PT for Patient #4 confirmed she had not performed supervisory visits for the home health aide as required.</p> <p>The agency did not provide PT supervision of the home health aide for Patient #4.</p>	G 228	<p><i>Refer to POC dated 4/17/13</i></p>	
G 242	<p>484.52 EVALUATION OF THE AGENCY'S PROGRAM</p> <p>This CONDITION is not met as evidenced by: Based on review of agency policies,</p>	G 242	<p><i>Refer to plan of correction dated 4/8/13. Compliance date 4/17/13.</i></p> <p><i>Julie Bennett, Administrator</i> <i>4/8/13</i></p>	

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

PRINTED: 03/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/11/2013
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G 242	<p>Continued From page 48</p> <p>administrative documentation, and staff interview, it was determined the agency failed to ensure an evaluation of the agency's program was completed. This resulted in the inability of the agency to evaluate patient care services and generate changes to improve the delivery of those services. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to G244 as it relates to the agency's failure to ensure an annual evaluation including an overall policy, administrative, and clinical record review was completed. 2. Refer to G245 as it relates to the agency's failure to ensure an annual evaluation was performed to assess the extent to which the agency's program was appropriate, adequate, effective and efficient. 3. Refer to G248 as it relates to the failure of the agency to ensure an annual evaluation was completed that included review of the agency's policies and administrative practices. 4. Refer to G250 as it relates to the agency's failure to include all health professionals in chart audits representing the scope of the program as part of the quarterly record review. <p>The cumulative effect of these negative systemic practices seriously impeded the ability of the agency to provide services of adequate quality.</p>	G 242		
G 244	<p>484.52 EVALUATION OF THE AGENCY'S PROGRAM</p> <p>The evaluation consists of an overall policy and administrative review and a clinical record review.</p>	G 244	<p><i>Refer to POC dated 4/8/13</i></p>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

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G 244	Continued From page 49 This STANDARD is not met as evidenced by: Based on staff interview and review of administrative documents and meeting minutes, it was determined the agency failed to ensure an annual evaluation, including an overall policy review and a clinical record review, was conducted annually. This resulted in a lack of feedback to determine whether agency programs met patient needs. Findings include: PAC meeting minutes, dated 1/25/12 stated agency policies had been reviewed. Neither an annual evaluation of the agency's program nor clinical record review were mentioned in the minutes. No other PAC minutes were present through 3/11/13. No other documentation was present that an evaluation of the agency's program had been conducted. The Administrator was interviewed on 3/11/13 at 2:00 PM. She stated an evaluation of the agency's program had not been conducted in 2012 or 2013.	G 244		
G 245	The agency did not conduct an annual evaluation. 484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient. This STANDARD is not met as evidenced by: Based on review of administrative records and staff interview, it was determined the agency	G 245	<i>Refer to POC dated 4/8/13</i>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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G 245	Continued From page 50 failed to ensure an annual agency evaluation was conducted which assessed the extent to which the agency's program was appropriate, adequate, effective and efficient. This resulted a lack of feedback to agency staff to assist them to improve patient care. Findings include: Documentation of an evaluation of the agency's program was not present for 2012 or 2013. The Administrator was interviewed on 3/11/13 at 2:00 PM. She stated an evaluation of the agency's program which included a determination of the extent to which the agency's program was appropriate, adequate, effective and efficient, had not been conducted in 2012 or 2013.	G 245		
G 248	The agency did not conduct an annual evaluation. 484.52(a) POLICY AND ADMINISTRATIVE REVIEW As part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient. This STANDARD is not met as evidenced by: Based on review of administrative documents and staff interview, it was determined the agency failed to ensure an annual evaluation, including an evaluation of the policies and administrative practices of the agency, was conducted. This resulted in a lack of feedback to agency staff. Findings include:	G 248	<i>Refer to POC dated 4/8/13</i>	

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

PRINTED: 03/28/2013
FORM APPROVED
OMB NO. 0938-0391

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G 248	<p>Continued From page 51</p> <p>PAC meeting minutes, dated 1/25/12 stated agency policies had been reviewed. Neither an annual evaluation of the agency's program nor clinical record review were mentioned in the minutes. No other documentation was present that policies had been evaluated through 3/11/13. No other documentation was present that an evaluation of the agency's program had been conducted.</p> <p>The Administrator was interviewed on 3/11/13 at 2:00 PM. She stated an evaluation of the agency's program had not been conducted in 2012 or 2013. She stated agency policies had not been evaluated since 1/25/12. She stated the PAC was scheduled to meet soon but an evaluation of the agency's program had not been conducted in the past year.</p>	G 248		
G 250	<p>484.52(b) CLINICAL RECORD REVIEW</p> <p>At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of chart audit results and policies, it was determined the agency failed to include health professionals representing the scope of the program as part of the quarterly record review. This resulted in an incomplete</p>	G 250	<p><i>Refer to POC dated 4/8/13</i></p>	

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

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G 250	<p>Continued From page 52 review. Findings include:</p> <p>1. The agency provided nursing as well as home health aide, social services, PT, OT, and ST.</p> <p>The Administrator was interviewed on 3/11/13 at 2:00 PM. She stated one quality assurance staff member, an RN, reviewed 100 percent of all clinical notes. The review included content, coding, and completeness. The Administrator stated there was no data produced from the reviews in order to determine whether established policies are followed.</p> <p>A comprehensive review of open and closed records was not completed. Additionally, the agency did not utilize appropriate health professionals to review clinical records to determine whether established policies are followed</p> <p>2. The undated policy, "CLINICAL RECORD REVIEW," stated "The clinical record review is performed by a multidisciplinary team." The policy did not state which disciplines would be represented on the team.</p> <p>The Administrator was interviewed on 3/11/13 at 2:00 PM. She stated only one person conducted any form of clinical record reviews.</p>	G 250		
G 331	<p>484.55(a)(1) INITIAL ASSESSMENT VISIT</p> <p>A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for</p>	G 331	<p><i>Refer to PDC dated 4/8/13</i></p>	

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

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G 331	<p>Continued From page 53</p> <p>Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.</p> <p>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 the initial SOC comprehensive assessment included a thorough examination of identified items of concern for 5 of 12 patients (#6, #8, #9, #11, and #12) whose records were reviewed. This had the potential to lead to incomplete development of plans of care and monitoring of patient health status. Findings include:</p> <p>The undated policy "COMPREHENSIVE ASSESSMENT AND OASIS DATA COLLECTION; START OF CARE" included, "Care of clients is based upon a comprehensive assessment process. It is established by the organization in coordination with the regulatory requirements to gather and analyze specific data to determine the initial and continuing health care needs and services of the client and client care outcomes. The comprehensive assessment will include: Primary and secondary diagnosis and ...Medical history including dates." This policy was not followed. Examples include:</p> <p>1. Patient #11 was a 42 year old female admitted to the HHA on 10/03/12 for an abdominal wound following gastric bypass surgery. An H&P, dictated by Patient #11's physician on 9/19/12, stated Patient #11 had a diagnosis of insulin dependent diabetes. The H&P also stated Patient #11 was taking an oral medication for diabetes.</p>	G 331	<p><i>Refer to POC dated 4/8/13</i></p>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

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G 331	<p>Continued From page 54</p> <p>The "START OF CARE ASSESSMENT/RESUMPTION OF CARE," dated 10/03/12, contained the following discrepancies related to Patient #11's diabetic condition:</p> <ul style="list-style-type: none"> - In the section "Current Illness" diabetes was listed as a diagnoses. However, in the section "Endocrine and Hematopoietic:" the RN did not check the box labeled diabetes. In the section "Plan of Care Synopsis" the RN checked "Yes" indicating diabetic foot care would be provided to Patient #11. <p>Subsequently, the POT for the certification period of 10/03/12 through 12/01/12 included a diagnosis of Diabetes Mellitus Type II but did not include interventions related to the management of diabetes or medications for the treatment of diabetes. Skilled nursing notes from 10/03/12 through 11/16/12 were reviewed. There was no documentation of interventions related to diabetes.</p> <p>The RN who completed the SOC assessment and provided care for Patient #11 was interviewed on 3/08/13 at 8:15 AM. He stated he was unaware Patient #11 was diabetic and that was why he did not mark the box labeled diabetes on the SOC assessment. He stated that when he does the SOC assessment, he does not ask every patient if they have a history of diabetes. He stated his practice was to review the H&P that is provided and ask questions based on the H&P. The RN reviewed the H&P and confirmed it stated Patient #11 was an insulin-dependent diabetic. He then stated that "a lot of time the H&P will be wrong and the patient has never even</p>	G 331	<p><i>Refer to POC dated 4/8/13</i></p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 331	<p>Continued From page 55</p> <p>had some of this stuff." He confirmed the POT included diabetes as a diagnoses. He confirmed that the POT is generated from the SOC assessment and that he reviews the POT before it is sent to the physician. He confirmed skilled nursing did not perform any interventions related to diabetes for Patient #11.</p> <p>The DCS was reviewed the record and was interviewed on 3/08/13 at 11:50 AM. He confirmed the SOC assessment was unclear as to whether Patient #11 had a diagnosis of diabetes. He confirmed the H&P indicated Patient #11 had insulin dependent diabetes and stated there was no reason to assume this was in some way incorrect.</p> <p>The SOC assessment was inconsistent in documentation of existing diagnoses.</p> <p>2. Patient #9 was a 63 year old male who was admitted to the HHA on 2/17/13 for care after hip surgery. The "START OF CARE ASSESSMENT/RESUMPTION OF CARE," dated 2/19/13, contained the following discrepancies:</p> <p>a. The SOC assessment indicated a goal that Patient #9's depression will be controlled with medication. The SOC also indicated Patient #9 was assessed on a "PHQ- 2" scale, which is used to assess the risk of depression. The scale indicated Patient #9 felt "down, depressed or hopeless" more than half the days in a two week period. The scale also indicated Patient #9 found "little interest or pleasure in doing things" more than half the days in a two week period. However, under the section "Mental Status" the box labeled "Depressed" was not checked.</p>	G 331	<p><i>Refer to POC dated 4/8/13</i></p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2013	
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G 331	<p>Continued From page 56</p> <p>The POT for the certification period 2/17/13 through 4/17/13 was reviewed. The POT included a goal of "Patients depression will be controlled with medication as evidenced by increased mood and no self harm times 4 weeks." The POT also listed the medication Patient #9 was taking. There were no medications on the POT for depression.</p> <p>The RN that completed the SOC assessment reviewed the record and was interviewed on 3/07/13 at 8:40 AM. She stated that she included the goal related to depression after talking with Patient #9 and concluding he was depressed. She stated the goal related to depression was taken from a template that was given to her by the former Clinical Director and did not accurately reflect Patient #9's status. She confirmed Patient #9 was not on any medications to treat depression. She also stated Patient #9 had not verbalized ideation of harming himself. She stated that she should have notified Patient #9's physician about the results of the "PHQ-2" scale, as it indicated to her Patient #9 was depressed, and gotten an order for antidepressant medication.</p> <p>b. The SOC assessment indicated Patient #9 wore glasses and had partially impaired vision, which meant that he "cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout..." A statement on the assessment form stated the patient's vision was to be assessed with glasses on.</p> <p>PT services were observed on 3/05/13 beginning at 1:35 PM. Immediately following this</p>	G 331	<p><i>Refer to POC dated 4/8/13</i></p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2013
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G 331	<p>Continued From page 57</p> <p>observation, Patient #9 was observed reading the labels of his medication bottles. Also during this observation, Patient #9's roommate stated he had been trying to collect newspapers for Patient #9 because Patient #9 loved to read.</p> <p>The RN that completed the SOC assessment reviewed the record and was interviewed on 3/07/13 at 8:40 AM. She stated she misunderstood the section related to vision status on the SOC assessment. She stated she interpreted the question as Patient #9's vision capabilities without glasses, not with glasses. She stated she is still in the process of learning how to complete the SOC assessment.</p> <p>The SOC assessment was inaccurate and contained unclear information related to diagnoses.</p> <p>3. Patient #8 was a 79 year old female admitted to the HHA on 2/07/13 for abdominal wounds, diabetes, high blood pressure, and COPD. The "START OF CARE ASSESSMENT/RESUMPTION OF CARE," dated 2/06/13, contained the following discrepancies:</p> <ul style="list-style-type: none"> - In the "Pain" portion of the assessment, the RN documented the location of pain as the "rash wounds on (abdomen) under pannus [a flap of excess skin, fat and tissue at the bottom of the abdomen], groin area." - In the section "Type of Lesion(s):" the RN documented "open (stage) 2 started as yeast infection." - In the section "Stage of Most Problematic 	G 331	Refer to SOC dated 4/17/13	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/11/2013
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G 331	<p>Continued From page 58</p> <p>(Observable) Pressure Ulcer." the RN did not mark the box indicating the wound was stage 2. The RN marked "N/A - No observable pressure ulcer or unhealed pressure ulcer."</p> <p>- The RN documented that the wound "Started as yeast infection (between) pannus (and) groin area then opened up (stage) 2 red, pink (with) small amount of serous drainage (and) yellow eschar."</p> <p>The RN who completed the assessment reviewed the medical record and was interviewed on 3/08/13 at 9:10 AM. She stated that Patient #8 had developed a yeast infection under her pannus and then developed small wounds under her pannus and in her groin area. She stated she documented the wounds as stage 2 because they were open, but stated she was not sure if that was accurate. The RN stated she was unsure how to accurately document these wounds as she had not had very much training on completing the SOC assessment. She agreed the assessment was unclear as to what type of wounds Patient #8 had.</p> <p>Documentation of wounds on the SOC assessment was unclear.</p> <p>4. Patient #6 was an 88 year old male admitted to the HHA on 2/15/13 for edema, high blood pressure and spinal stenosis. The "START OF CARE ASSESSMENT/RESUMPTION OF CARE," dated 2/14/13, contained the following discrepancies:</p> <p>The SOC assessment indicated Patient #6 wore glasses and had normal vision, which meant he could see adequately in most situations. The</p>	G 331	<p><i>Refer to POC dated 4/8/13</i></p>		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/11/2013
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G 331	<p>Continued From page 59</p> <p>SOC assessment also indicated Patient #6 wore glasses and contacts. A hand written note indicated the left eye contact had been removed.</p> <p>Skilled Nursing services were observed on 3/05/13 beginning at 10:20 AM. During the observation it was noted that Patient #6 was not wearing glasses. Immediately following the observation, Patient #6's medications were reviewed with him. He stated he was taking eye drops for a cataract surgery on his left eye in 2012. There was no documentation of this on the SOC assessment.</p> <p>The RN who completed the SOC assessment was interviewed on 3/07/13 at 10:20 AM. She stated she was not aware of Patient #6 having cataract surgery. After reviewing the medical record she then stated she may have known about the cataract surgery and marked left contact removed by mistake. She stated Patient #6 did not wear contacts.</p> <p>The SOC assessment was inaccurate.</p> <p>5. Patient #12 was a 69 year old female admitted to the agency on 1/21/13 for home health services related to paralysis and pressure ulcer that required wound care.</p> <p>The "START OF CARE ASSESSMENT," dated 1/21/13, listed diagnoses which included osteomyelitis and stage 4 pressure ulcer. Subsequently, the POT for the certification period 1/21/13 to 3/21/13 contained diagnoses of osteomyelitis (infection of the bone) and decubitus of the buttock.</p>	G 331	<p><i>Refer to POC dated 4/8/13</i></p>	

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

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G 331	<p>Continued From page 60</p> <p>During an interview on 3/07/13 beginning at 11:00 AM, the RN Case Manager reviewed Patient #12's medical record and stated the diagnoses of stage 4 pressure ulcer as well as the osteomyelitis was not a current problem with Patient #12. She stated Patient #12 had gone to another state last year and had been hospitalized for osteomyelitis and it had been treated and resolved. She stated Patient #12 had then undergone surgical repair for the stage 4 pressure ulcer, so that had resolved as well. The RN stated Patient #12 had a separation of the surgical wound, which was classified at the SOC as a stage 2, for which she was receiving wound care. The RN stated she had not written the diagnoses on the SOC assessment, but had left the areas blank.</p> <p>In an interview on 3/07/13 beginning at 1:30 PM, the Administrator reviewed Patient #12's record and confirmed she had written the diagnoses on the SOC assessment. The Administrator stated during the patient admission process the case manager would complete a coding worksheet, and that information would be used to determine the diagnosis and ICD 9 code.</p>	G 331	
G 337	<p>The START OF CARE ASSESSMENT for Patient #12 did not contain accurate information.</p> <p>484.55(c) DRUG REGIMEN REVIEW</p> <p>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.</p>	G 337	<p><i>Refer to ADC dated 4/8/13</i></p>

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

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G 337	Continued From page 61 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 6 of 12 patients (#3, #4, #5, #6, #8, and #9) whose records were reviewed. Failure to obtain an accurate patient medication list or to evaluate the list for duplicative therapy, drug interactions, or significant side effects had the potential to place patients at risk for adverse events or negative drug interactions. Findings include: The "MEDICATION ADMINISTRATION" policy, undated, included, "A medication profile, completed for each client at the time of admission, will be updated as indicated and reviewed at least every 60 days. The profile will include the name of the drug, date ordered, dose, route, frequency, duration of therapy if appropriate and action or use. This profile will include over-the-counter drugs." The "MEDICATION ADMINISTRATION" policy, undated, contained a section that discussed new or changed medications. The policy included, "Medication changes will be documented on the nursing/therapy note when the case manager becomes aware of the change. ...New medications will be identified by the Rx number on the bottle and the patient's medication profile will be updated in the computer by the QA Director or his/her designee. All changes in the previously prescribed medications will be verified with the physician on the Physician Fax Sheet and when the order is returned signed, the	G 337	<i>Refer to PDC dated 4/8/13</i>		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

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G 337	<p>Continued From page 62</p> <p>patient's medication profile will be updated in the computer by the Clinical Coordinator or his/her designee."</p> <p>A complete review of medications did not occur in the following examples:</p> <p>1. Patient #6 was an 88 year old male who was admitted to the agency on 2/15/13 for edema and high blood pressure.</p> <p>A form titled "Medication Profile," unsigned, documented the medications Patient #6 was taking at the time of admission. It included:</p> <ul style="list-style-type: none"> - Amlodipine 10 mg orally daily, - Lecithin 1200 mg orally daily, - Lisinopril 40 mg orally daily, - Omega 3 Fish Oil 500 mg orally daily, - Vitamin D 3000 units orally daily. <p>The same medications were listed on Patient #6's POT for the certificaion period of 2/15/13 through 4/15/13.</p> <p>On a SN home visit on 3/05/13 starting at 10:20 AM, surveyors completed a review of medications with Patient #6. Patient #6 confirmed the above medications and dosages. Also at this time, several eye drop bottles and a bottle of Aspirin were observed on a small table in the living area directly beside Patient #6's recliner. Patient #6 stated he was taking eye drops for a removal of a cataract on his left eye done in 2012. These eye drops were Ketorolac (non-steroidal anti-inflammatory), Prednisone (steroid), and Vigamox (antibiotic). He stated he applied a drop to his left eye each day. Patient #6 also stated he</p>	G 337	<p><i>Refer to ADC dated 4/8/13</i></p>		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

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G 337	<p>Continued From page 63</p> <p>was taking an 81 mg Aspirin most days. The Prednisone, Ketorolac, Vigamox and Aspirin were not included in Patient #6's medication profile and POT.</p> <p>The RN who provided care for Patient #6 reviewed the medical record and was interviewed on 3/07/13 at 10:20 AM. She stated she was unaware that Patient #6 was taking the eye drops and Aspirin. She stated she did not review Patient #6's medications each time she visited him.</p> <p>The medication list and POT in Patient #6's medical record were not accurate and current on the date of the home visit.</p> <p>2. Patient #9 was a 63 year old male who was admitted to the agency on 2/17/13 following discharge from a skilled nursing facility after being treated for a left hip fracture, ESRD, and high blood pressure.</p> <p>A form titled "Medication Profile," signed by a physician on 2/28/13, documented the medications Patient #9 was taking at the time of admission. It included:</p> <ul style="list-style-type: none"> - Nephro Vit 1 tablet orally daily, - Procardia XL 60 mg orally daily, - Renvela 800 mg 5 tablets orally with meals, - Norco 10/325 mg 1-2 tablets orally every 6 hours as needed for pain, - Oxycodone 5 mg orally every 4 hours as needed for pain, - Flexeril 5 mg orally every 8 hours as needed - Metoprolol 25 mg orally daily - Colace 100 mg orally twice a day as needed for 	G 337	<p><i>Refer to POC dated 4/8/13</i></p>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2013
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G 337	<p>Continued From page 64 constipation</p> <p>The same medications were listed on Patient #9's POT for certification period 2/17/13 through 4/17/13.</p> <p>During a PT home visit on 3/06/13 at 1:35 PM, surveyors completed a review of medications with Patient #9. Discrepancies were noted in comparison to the medications listed on the POT and "Medication Profile." Patient #9 stated he had never had a prescription for Oxycodone. He stated he took it while he was in the hospital and skilled nursing facility but had never taken it once discharged.</p> <p>Patient #9 also stated he had a bottle of Reglan for nausea. He stated it was given to him when he was discharged from the nursing home. The Reglan was not included on the POT and "Medication Profile."</p> <p>The DCS reviewed Patient #9's record and was interviewed on 3/08/13 at 10:40 AM. He confirmed he had completed the "Medication Profile" for Patient #9. He stated he believed he had seen the medication Oxycodone at the time the "Medication Profile" was completed but he could not recall for sure. He stated he was unaware Patient #9 was taking Reglan.</p> <p>The POT and medication list in Patient #9's medical record was not accurate and current on the date of the home visit.</p> <p>3. Patient #8 was a 79 year old female admitted to the agency on 2/07/13 for treatment of abdominal wounds, cellulitis and high blood</p>	G 337	Refer to POC dated 4/18/13	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/11/2013
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G 337	<p>Continued From page 65 pressure.</p> <p>A form titled, "Medication Profile," signed by the RN on 2/21/13, documented the medications Patient #8 was taking at the time of admission, and included:</p> <ul style="list-style-type: none"> - Cephalexin 500 mg orally 4 times a day, stopped 2/15/13 - Albuterol Inhaler, 2 puffs inhaled every 4-6 hours as needed for wheezing, - Amlodipine 10 mg orally daily, - Aspirin 81 mg orally daily, - Ambien 10 mg orally daily, - Clotrimazole ointment to apply to wounds twice a day, - Fish oil 1000 mg orally daily, - Insulin Glargine 30 units injected twice a day, - Insulin Lispro 10 units injected before meals, - Lasix 40 mg orally daily as needed, - Metolazone 2.5 mg orally daily, - Nabumetone 500 mg orally twice a day, - Simvastatin 20 mg orally daily, - Trazadone 150 mg 1.5 tablets orally daily - Vicodin 5/500 mg orally every 6 hours as needed for pain <p>The same medications were listed on Patient #8's POT for certification period 2/07/13 through 4/07/13.</p> <p>Wound care orders, signed by the physician on 2/14/13, included Dermaklenz and Nystop powder. These were not listed on the medication profile.</p> <p>During an observation of a Skilled Nursing visit on 3/07/13 beginning at 11:05 AM, the RN performed</p>	G 337	<p><i>Refer to POC dated 4/8/13</i></p>		

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

PRINTED: 03/26/2013
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G 337	<p>Continued From page 66</p> <p>an assessment of Patient #8. During the assessment, Patient #8 stated she had been taking a stool softener as needed for constipation and that she had a "huge bottle" of stool softener pills with her. The RN stated she was unaware of this and asked if this was ordered by Patient #8's physician. Patient #8 stated no, she got the stool softener over the counter and had been taking it for "a while." The RN stated she would notify Patient #8's physician of the stool softener.</p> <p>Also during this observation, the RN provided wound care and applied the Nystop powder. The RN did not apply Clotrimazole. When asked if Clotrimazole was intended for the wound, the RN stated it was. She stated she never used it because it caused too much moisture around the wound area. She stated that she should have notified Patient #8's physician that she was not using the Clotrimazole.</p> <p>The medication list and POT in Patient #8's medical record was not accurate and current on the date of the home visit.</p> <p>4. Patient #3's medical record documented a 67 year old female who was admitted for home health services on 11/20/12. She was currently a patient as of 3/04/13. She had a failed total knee replacement in 2012 which later became infected. Current diagnoses included rheumatoid arthritis and depression. Patient #3's "Medication Profile," dated 11/20/12, stated she had 2 separate antidepressants, Effexor and Zoloft. The POT dated 11/20/12, included the same medications.</p> <p>Patient #3's "Medication Profile" was faxed to the physician on 11/21/12. However, the profile did</p>	G 337	<p><i>Refer to POC dated 4/8/13</i></p>	

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

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G 337	<p>Continued From page 67 not identify duplicate medications.</p> <p>Patient #3's RN Case Manager was interviewed on 3/06/13 beginning at 8:55 AM. He confirmed the information regarding Patient #3's medications was not communicated with the physician.</p> <p>The agency did not identify duplicate drug therapy for Patient #3.</p> <p>5. Patient #4 was an 86 year old female admitted to the agency on 1/08/13 for home health services related to pneumonia, generalized muscle weakness, and arthritis.</p> <p>The POT for the certification period 1/07/13 through 3/07/13 contained a list of medications Patient #4 was taking. During a home visit to observe care provided by the HHA on 3/06/13 beginning at 10:45 AM, a review of medications was performed with Patient #4. Discrepancies were noted in comparison to the medications listed on the POT as follows:</p> <ul style="list-style-type: none"> - Hydroxychloroquine, 200 mg, one daily, (The POT stated the dosage as 1200 mg) - Allopurinol 100 mg, one daily, (Not included on the POT) - Omeprazole 20 mg, one daily, (Not included on the POT) - Probiotic one daily, (Not included on the POT) - Loperamide as needed, (Not included on the POT) - Fiber capsules as needed, (Not included on the POT) - Probiotic 10 as needed, (Not included on the POT) 	G 337	<p><i>Refer to POC dated 4/8/13</i></p>	

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G 337	<p>Continued From page 68</p> <ul style="list-style-type: none"> - Nature Multivitamins one daily, (Not included on the POT) - Beano as needed, (Not included on the POT). <p>In an interview on 3/08/13 beginning at 9:40 AM, the PT Case Manager reviewed Patient #4's record. She stated her process for medication review on SOC was to review the hospital's medication list on discharge with the medications provided by the patient during that visit. She stated she would verbally ask for updates for changes during visits but patients did not always reveal all medications. As for the Hydroxychloroquine dose (written as 1200 mg, not 200 mg as written on the container) the PT stated she may have misread the label or it was a typo on her part.</p> <p>Patient #4 was taking medications that were not included on the POT.</p> <p>6. Patient #5 was a 93 year old female who was admitted to the agency on 2/05/13 for care related to diabetes, hypertension, and abnormal gait.</p> <p>The POT for the certification period 2/05/13 through 4/05/13 contained a list of medications Patient #5 was taking. During a SN home visit on 3/05/13 starting at 11:15 AM, the RN completed a review of medications with Patient #5. Discrepancies were noted in comparison to the medications listed on the POT. Patient #5 stated she was taking Docusate (a stool softener) three tablets at night as well as Miralax, a laxative. Patient #5 stated she had been taking the Docusate for many years. The 2 medications were not included on the POT.</p>	G 337	<p><i>Refer to POT dated 4/8/13</i></p>	

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

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 2950 EAST MAGIC VIEW DR, STE 100 MERIDIAN, ID 83642		
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G 337	Continued From page 69 In an interview on 3/08/13 beginning at 9:00 AM, the RN Case Manager stated he was previously unaware Patient #5 had been using the stool softener and laxative. He stated he reviewed both medications with the patient at the time of the observed visit. The RN confirmed he had not contacted the physician to include the medications on the POT or to clarify if the medications were approved by the physician. Patient #5 was taking medications that were not included on the POT.	G 337	<i>Refer to PC dated 4/8/13</i>		

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FACILITY STANDARDS

4/8/2013

Family Home Health

Plan of correction survey results 2013

FAMILY HOME HEALTH

Contents

ACKNOWLEDGMENTS2

G 114: 484.10(e) PATIENT LIABILITY FOR PAYMENT3

G 130: 484.14(b) GOVERNING BODY4

G 132: 484.14(b) GOVERNING BODY5

G133: 484.14(c) ADMINISTRATOR.....7

G 144: 484.14(g) COORDINATION OF PATIENT SERVICES8

G151: 484.16 GROUP OF PROFESSIONAL PERSONNEL9

G152: 484.16 GROUP OF PROFESSIONAL PERSONNEL10

G153: 484.16 GROUP OF PROFESSIONAL PERSONNEL11

G154: 484.16(a) ADVISORY AND EVALUATION FUNCTION12

G 156: 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER13

G 158: 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER14

G 159: 484.18(a) PLAN OF CARE15

G 164: 484.18(b) PERIODIC REVIEW OF THE PLAN OF CARE16

G 165: 484.18© CONFORMANCE WITH PHYSICIAN'S ORDERS.....17

G 228: 484.36(d) (1) SUPERVISION.....18

G 242: 484.52 EVALUATION OF THE AGENCY'S PROGRAM19

G244: 484.52 EVALUATION OF THE AGENCY'S PROGRAM20

G245: 484.52 EVALUATION OF THE AGENCY'S PROGRAM21

G248: 484.52 (a) POLICY AND ADMINISTRATIVE REVIEW.....22

G 250: 484.52(b) CLINICAL RECORD REVIEW23

G 331: 484.55(a) (1) INITIAL ASSESSMENT VISIT24

G 337: 484.55© DRUG REGIMEN REVIEW25

Attachment A: SHARQ27

Attachment B: Recertification/Discharge Tool.....28

Attachment C: Chart Audit Tool29

ACKNOWLEDGMENTS

As Administrator of Family Home Health I Julie Burnett acknowledge these changes as identified by the plan of correction document. I further will do all within my capacity to ensure that the following changes are implemented and followed as identified. I understand deviations from the conditions of participation as outlined by State and Federal regulations must be corrected timely.



Julie Burnett, Administrator



Date

G 114: 484.10(e) PATIENT LIABILITY FOR PAYMENT

Family Home Health Staff has been educated on 3/19/13 of the following changes to patient consents in regards to Patients liability for payment. Staff responsibility upon initiation of services is to present in writing to the patient or legal representative their financial responsibility for payment of home health services. This is performed using the form "Admission to Home Care: Consents/Terms Conditions/Releases". The identified sections Authorization for Government Program Benefits and Financial Responsibility outline the specific cost of services and the patient's liability for payment of these services. Along federal and State guidelines patients with Medicare and Medicaid have no out of pocket expense for any home health services rendered by Family Home Health. Patients not enrolled with Medicare/Medicaid will be presented with specific cost breakdown for all services rendered by Family Home Health at the time of admission. In both cases all patients or their legal representative must agree to sign and verbalize understanding of their liability for payment prior to initiation of home health services.

AUTHORIZATION FOR GOVERNMENT PROGRAM BENEFITS

I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I request that payment of authorized benefits be made directly to Family Home Health. I understand I will receive written notice from Family Home Health if services are not authorized under Medicare or Medicaid. I understand services are expected to be fully paid by Medicare/Medicaid or government program (100% Coverage by Medicare/Medicaid).

FINANCIAL RESPONSIBILITY (None to Patient if traditional Medicare/Medicaid)

Medicare. 100% Benefit Coverage. Medicare beneficiaries will not receive a bill for any Family Home Health services. If the agency expects Medicare payment for physician ordered services not included in the Family Home Health Services provided, the agency will notify me, orally and in writing, before services are initiated or continued.

PRIVATE INSURANCE/SELF PAY

INSURANCE: Patient is or is not covered by private medical insurance. (Complete if applicable.) Name of insurance company and type of plan: Insurance Company: Policy Number:
Employer or Group #: _____ Amount of Coverage: Contact Person:
Type of Plan: (Circle one) Individual/Group
Policy covers home care services requested: Yes No Managed Care Plan: Yes No
Patient's out-of-pocket charges: \$___ per visit
(Patients receiving services under Medicare, have no out-of-pocket expenses, for Homebound Skilled Home Health Services)

MODIFICATIONS:

No oral statement of any person shall modify or otherwise affect the foregoing terms and conditions.

G 130: 484.14(b) GOVERNING BODY

The Governing Body arranges for professional advice as required under 484.16.

The Board of Directors (aka) The Governing Body of the Corporation has made a change in who its' members are in order to allow more effective and efficient management of the Agency. This change was effective on April 1, 2013. Steven R. Horton will be stepping away from his duties as Secretary of the Governing Body and replaced by Julie Burnett. Michael Dempsey will remain on the Governing Body as President.

The change in appointing Julie Burnett as a member of the Governing Body will allow her, as the Administrator, to take the necessary action to ensure the Agency is in compliance by coordinating with just one individual instead of two.

The Governing Body met on April 1, 2013 and agreed upon who the members of its' Advisory Committee will be for 2013. Those members are as follows:

Julie Burnett- Administrator, FHH [REDACTED] me

Jake Overall- RN, BSN, DOCS, FHH [REDACTED]

[REDACTED] [REDACTED]

[REDACTED] [REDACTED]

[REDACTED]

A Professional Advisory Committee (PAC Meeting) is scheduled to be held on April 10, 2013 at 9:00am with all attendees mentioned above.

The Administrator will be responsible to ensure the PAC meeting will occur twice within a calendar year. The first meeting will occur before April 10th of each year and the second PAC meeting will occur before October 31st of this year and each year following.

G 132: 484.14(b) GOVERNING BODY

The governing body oversees the management and fiscal affairs of the agency.

The Governing Body met on April 1, 2013 and agreed upon who the members of its' Advisory Committee will be for 2013. Those members are as follows:

- Julie Burnett- Administrator, FHH [REDACTED]
- Jake Overall- RN, BSN, DOCS, FHH [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

A Professional Advisory Committee (PAC) is scheduled to be held on April 10, 2013 at 9:00am with all attendees mentioned above.

The Agenda for the scheduled meeting is as follows:

1. Defining the Professional Advisory Committee.
2. Evaluation process:
 - Assurance/Evaluation of existing or potential problems
 - Capacity of Overcome
 - Services offered meet objectives of Agency and patient outcomes
 - Minimal expenditures of resources to achieve desired goals and outcomes.
3. Review of Policies by PAC
 - Admission Criteria
 - Discharge Criteria
 - Coordination of Patient Care
 - Plans of Care
 - Clinical Records Review
 - Personnel Qualifications
 - Program Evaluation
4. Other Areas of Review
 - Marketing & Community Involvement
 - Contract Management
 - Personnel Management
5. Statistics
6. Committee Designations
 - QA
 - Finance
7. Other topics for comment/review

The Administrator will be responsible to ensure the PAC meeting is held twice each year and that all pertinent subjects are covered in those meetings.

The Director of Quality Assurance will present the previous quarters findings statistical data related to compliance with agency policies and completeness of clinical records. This data will be interpreted to determine the best course of action for ensuring Family Home Health adheres to Federal and State conditions of participation for home health services.

G133: 484.14(c) ADMINISTRATOR

The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, organizes and directs the agency's ongoing functions; maintains ongoing liaison among the governing body, the group of professional personnel, and the staff.

A Professional Advisory Committee (PAC) is scheduled to be held on April 10, 2013 at 9:00am with all attendees mentioned above. (G132)

The Administrator will be responsible to ensure the PAC meeting will occur twice within a calendar year. The first meeting will occur before April 10th of each year and the second PAC meeting will occur before October 31st of this year and each year following.

The Board of Directors (aka) The Governing Body of the Corporation has made a change in who its' members are in order to allow more effective and efficient management of the Agency. This change was effective on April 1, 2013. Steven R. Horton will be stepping away from his duties as Secretary of the Governing Body and replaced by Julie Burnett. Michael Dempsey will remain on the Governing Body as President.

The change in appointing Julie Burnett as a member of the Governing Body will allow her, as the Administrator, to take the necessary action to ensure the Agency is in compliance by coordinating with just one individual instead of two.

In addition, the Administrator has begun a computer journal to document her conversations with the other Board Member so it may be reviewed periodically and jointly signed.

Within (1) week of each Pac meeting the Administrator will meet with the Governing Body to discuss findings and recommendations from that meeting.

G 144: 484.14(g) COORDINATION OF PATIENT SERVICES

On 3/19/13 staff appointed position Case Conference Scribe is responsible for recording case conference minutes each week during case conference. Minutes are to include patient information and interchange communication between involved disciplines for each case being reviewed.

COMMUNICATION NOTES

With the integration of electronic charting via AxxessWeb all clinicians received training on 3/26/13 for the use of electronic communication notes. This allows clinicians to send messages allowing for adequate and detailed written communication to specific individuals involved in the case. All communication notes are received by the Director of Clinical Services and any other involved staff. Communication notes are generated for any condition that will affect the plan of care, any changes in patient condition or events that may affect the potential for reaching goals.

Missed visits will also be coordinated for the purpose of the missed visit. The Director of Clinical Services is responsible for ensuring that communication is occurring and will hold clinicians accountable for coordination of care throughout certification period.

On 4/2/13 Introduction of the SHARQ Assessment Tool and the Recertification/Discharge Assessment Tool. Case managers have been educated as to the function and purpose of these two forms in coordinating care and ensuring adequate and accurate communication is occurring between disciplines.

SHARQ Assessment Tool (Attachment A)

All new admissions paperwork will include the SHARQ Assessment tool to assist in coordination of care and communication between clinicians. The SHARQ tool will be reviewed at the time of the patient's first case conference.

Recertification/Discharge Assessment Tool (Attachment B)

Cases that are within two weeks of discharge or recertification must have a Recertification/Discharge Assessment Tool. This tool serves as a guide for patients that fall into criteria of recertification or discharge. This form is sent as a physician's order to provide written and verbal communication of the patient's progress throughout the certification period and will help guide the physician's decision in ordering a recertification period for the patient.

G151: 484.16 GROUP OF PROFESSIONAL PERSONNEL

A Group of Professional Personnel includes at least one physician and one registered nurse, and appropriate representation from other professional disciplines.

The Governing Body met on April 1, 2013 and agreed upon who the members of its' Advisory Committee will be for 2013. Those members are as follows:

Julie Burnett- Administrator, FHH

[REDACTED]

Jake Overall- RN, BSN, DOCS, FHH

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

A Professional Advisory Committee (PAC) is scheduled to be held on April 10, 2013 at 9:00am with all attendees mentioned above.

The Administrator in conjunction with the Advisory Committee will be responsible to appoint a Group of Professional Personnel by February 15th of every year.

G152: 484.16 GROUP OF PROFESSIONAL PERSONNEL

Refer to G152 as it relates to the agency's failure to appoint a group of professional personnel.

The Administrator in conjunction with the Advisory Committee will be responsible to appoint a Group of Professional Personnel by February 15th of every year.

The Governing Body met on April 1, 2013 and agreed upon who the members of its' Advisory Committee will be for 2013. Those members are as follows:

Julie Burnett- Administrator, FHH

[REDACTED]

Jake Overall- RN, BSN, DOCS, FHH

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

G153: 484.16 GROUP OF PROFESSIONAL PERSONNEL

Refer to G153 as it relates to the agency's failure to ensure a group of professional personnel had reviewed the agency's policies on an annual basis.

A Professional Advisory Committee (PAC) is scheduled to be held on April 10, 2013 at 9:00am with all attendees mentioned above.

On the agenda for the PAC meeting to be held April 10, 2013, we will be discussing changes to our policies and soliciting the advice of the PAC members. Going forward we will continue to review and update as necessary (5) policies at each (bi-annual) PAC meeting. The Administrator in conjunction with the DOCS and the Governing Body will decide what those policies will be in advance of each PAC meeting.

The Agenda for the scheduled meeting is as follows:

1. Defining the Professional Advisory Committee.
2. Evaluation process:
 - Assurance/Evaluation of existing or potential problems
 - Capacity of Overcome
 - Services offered meet objectives of Agency and patient outcomes
 - Minimal expenditures of resources to achieve desired goals and outcomes.
3. Review of Policies by PAC
 - Admission Criteria
 - Discharge Criteria
 - Coordination of Patient Care
 - Plans of Care
 - Clinical Records Review
 - Personnel Qualifications
 - Program Evaluation
4. Other Areas of Review
 - Marketing & Community Involvement
 - Contract Management
 - Personnel Management
5. Statistics
6. Committee Designations
 - QA
 - Finance
7. Other topics for comment/review

The Administrator will be responsible to ensure the PAC meeting is held twice each year and that all pertinent subjects are covered in those meetings.

The Administrator will be responsible to ensure the PAC meeting will occur twice within a calendar year. The first meeting will occur before April 10th of each year and the second PAC meeting will occur before October 31st of this year and each year following.

G154: 484.16(a) ADVISORY AND EVALUATION FUNCTION

The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program.

The Administrator will be responsible to ensure the PAC meeting will occur twice within a calendar year. The first meeting will occur before April 10th of each year and the second PAC meeting will occur before October 31st of this year and each year following.

The Governing Body met on April 1, 2013 and agreed upon who the members of its' Advisory Committee will be for 2013. Those members are as follows:

Julie Burnett- Administrator, FHH

[REDACTED]

Jake Overall- RN, BSN, DOCS, FHH

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

One of the topics on the Agenda for the scheduled PAC meeting to be held April 10, 2013 is Marketing and Community Involvement which will be covered by Tami Taylor, who is the Community Liaison Director of Family Home Health. This topic will be covered in each PAC meeting going forward. Tami has ongoing responsibility for this role and provides weekly reports to the Administrator who then reports this information on a monthly basis to the Governing Body.

G 156: 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER

With the implemented changes and updates as outlined in G158, G159, G164, G165 Case POTs will be regularly reviewed and updated as needed to ensure that patient are receiving care according to their changing needs. This will also ensure that the patient is receiving continuity of care between all disciplines as the plan of care will be reviewed by all clinicians involved in the case at the time of the update.

G 158: 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER

Clinical staff trained on the following requirements on 4/9/13. All written plans of care will be followed as written and any changes to the plan of care must be approved by the attending physician. Attending physicians will be a doctor of medicine, osteopathy, or podiatric medicine and will have an active good standing license in the state of Idaho. Orders signed by physicians outside of these regulations will not be accepted as authorized orders. No care will be provided by the Home Health Agency without verbal or written orders from an approved physician. All verbal orders will be sent for signature and returned within sixty days of verbal order date or by the end of the episode for which the verbal order was received.

Using our newly implemented electronic charting all patients' plans of cares (485) are generated at the time of the completion of the Oasis documentation. The plan of care is reviewed with the patient by the case manager and verbal orders are requested from the physician for frequency plans and initial goals are outlined to be approved by the attending physician. The written plan of care (485) is electronically signed and dated by the case manager and sent via fax to the attending physician. All 485 will be returned signed by the physician within thirty days of the verbal order date. This will be monitored by clerical staff and case managers will be notified when the signed (485) is returned. The case manager will review the signed (485) for additional written instructions from the physician.

All care will be rendered according to the (485) and any deviation from the plan will be documented with physician orders to explain the deviation and necessary update to the plan of care. All clinicians involved in the case will receive written notification via Axxess messaging center at the time of deviation. No deviation of care will be permitted without verbal consent from the attending physician. This includes frequency changes, treatments, medication, ect...

All cases' plan of treatment will include parameters that will be assessed at each visit, unless deferred by the patient, and any findings outside of the physician approved parameters will be immediately called into the physician. Any orders received by the physician will be documented and sent for signature as orders, while all involved clinicians will be notified in writing of the findings via the Axxess communication center.

All treatments and medications that the patient is receiving will be recorded in the patient's medication record and must have written or verbal physician approval prior to administration. Periodic chart reviews will be performed by the Director of Quality Assurance to monitor for any discrepancies with the plan of care. Any significant changes in conditions experienced by the patient that result in a transfer of care will trigger a partial clinical record review by QA to help identify avoidable trends or potential problems. The results will be reviewed by the Director of Clinical Services to identify areas of needed education for clinicians.

G 159: 484.18(a) PLAN OF CARE

Clinical staff trained on the following requirements on 4/9/13. The plan of care will coincide with the patient's accurate health history as identified by physician visit notes or physician approved history and physical. All patient stated diagnoses or conditions not identified by the physician will be noted and sent to the patient's physician for verification and notification of symptoms. All pertinent diagnoses including mental status, types of services needed, durable medical equipment, frequency of visits outlined for each week of the episode, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items will be documented on the patients plan of care (485) for physician review and written approval by signature. A verbal order is received by the case manager at the generation of the plan of care (485) for physician approval and suggestions.

All care will be rendered according to the plan of care (485) and any deviation from the plan will be documented with physician orders to explain the deviation and necessary update to the plan of care. All clinicians involved in the case will receive written notification via Axxess messaging center at the time of deviation. No deviation of care will be permitted without verbal consent from the attending physician.

The plan of care (485) is reviewed by the case manager and involved clinicians, along with the Director of Quality Assurance on a regular bases to ensure that no care is being rendered outside of the plan of care without physician approval.

All pertinent diagnoses will have identified interventions and goals with expected outcomes documented on the plan of care. The physician will be notified of the patient's progress throughout the duration of care and will receive a written report for assessment of recertification or discharge orders prior to the patient being recertified or discharged. Each sixty day episode will include a sixty day case conference report detailing the physician on the patient's success or lack thereof for completion of the identified goals for the episode.

The Director of Clinical Services will ensure that the stated requirements for the plan of care are followed. The Director of Quality Assurance will report to the Director of Clinical Services annually and as needed. Training will be scheduled as needed for areas of weakness identified.

G 164: 484.18(b) PERIODIC REVIEW OF THE PLAN OF CARE

Clinical staff trained on the following requirements on 4/9/13. The plan of care (485) is reviewed by the case manager and involved clinicians, along with the Director of Quality Assurance on a regular bases to ensure that no care is being rendered outside of the plan of care without physician approval.

All care will be rendered according to the plan of care (485) and any deviation from the plan will be documented with physician orders to explain the deviation and necessary update to the plan of care. All clinicians involved in the case will receive written notification via Axxess messaging center at the time of deviation. No deviation of care will be permitted without verbal consent from the attending physician.

All cases plan of treatment will include parameters that will be assessed at each visit, unless deferred by the patient, and any findings outside of the physician approved parameters will be immediately called into the physician. Any orders received by the physician will be documented and sent for signature as orders, while all involved clinicians will be notified in writing of the findings via the Axxess communication center. Missed visit notes will be generate for any missed visits along with the reason for the missed visit. The Director of Clinical Services will be notified of all missed visits and the reason for the missed visit as well as the patient's case manager.

All treatments and medications that the patient is receiving will be recorded in the patient's medication record and must have written or verbal physician approval prior to administration. Periodic chart reviews will be performed by the Director of Quality Assurance to monitor for any discrepancies with the plan of care. Any significant changes in conditions experienced by the patient that result in a transfer of care will trigger a partial clinical record review by QA to help identify avoidable trends or potential problems. The results will be reviewed by the Director of Clinical Services to identify areas of needed education for clinicians. The Director of Quality Assurance will report to the Director of Clinical Services annually and as needed.

G 165: 484.18© CONFORMANCE WITH PHYSICIAN'S ORDERS

Drugs and treatments are administered by agency staff only as ordered by the physician.

Since the agency has now purchased a computer application to not only do 'point of care' by the clinical staff but to also manage the day-to-day Quality Assurance (QA) to ensure that the physician's orders are in place for all drugs and treatments.

During this transition to the computer, of course the staff is unsure of their responsibilities and what is expected of them. The agency is providing extensive training for the staff with individualized training for those with less computer literacy. During this period the QA RN will enter physician's orders for medications and treatments into the computer, send out communication notes to the staff to ensure their awareness of any updates, and closely scrutinize the clinical notes for documentation of changes in wound care, medications, or changes to the plans of care.

Currently, the Director of Clinical Services (DCS) has established an Excel Spreadsheet to track the plans of care to ensure they are timely and updated when necessary. This form will allow a quick reference for the Administrator, DCS, and QA RN to monitor the dressings ordered for wound care medications, wound sizing, visit frequency, and other changes that might occur and to ensure that the physician is notified of any things that would help the patient to regain and/or maintain their health status.

Under the auspices of the DCS and Administrator supervision the QA RN will be responsible for this hugely important part of Home Health Care. As above, the Excel spreadsheet was generated today (3/29/13). The review and transition to full computer use is and has been going on for about a month. On Tuesday, 4/9/13, there will be held a day long training session for the staff.

This is a large undertaking but once fully operational it will make it possible to provide numerical indices for the Governing Body and the Professional Advisory Committee so they will better be able to advise the Administrator and Staff to be able to meet the needs of the patients.

G 228: 484.36(d) (1) SUPERVISION

If the patient receives skilled nursing care, the registered nurse will perform the supervisory visit required at least every fourteen days that the patient is receiving home health aide visits. Supervisory visits are the responsibility of the case manager, if skilled nursing is not involved in the case then supervisory visits become the responsibility of the appointed case manager who is a licensed Physical Therapist, Occupational Therapists, or Speech–Language Pathologist.

Supervisory visits will be scheduled via Axxess scheduling center upon the initiation of aide services. They will be scheduled and completed at least every fourteen days. The Director of Clinical Services will monitor these visits and will be notified if any deviation of supervision occurs.

G 242: 484.52 EVALUATION OF THE AGENCY'S PROGRAM

Administrative review as outlined and detailed in G244, G245, G248, G250 will occur at least annually and will be assessed to ensure the agency's ability to provide quality adequate services in accordance with State and Federal conditions of participation for home health agencies.

G244: 484.52 EVALUATION OF THE AGENCY'S PROGRAM

The evaluation consists of an overall policy and administrative review and a clinical record review.

On the agenda for the PAC meeting to be held April 10, 2013, we will be discussing changes to our policies and soliciting the advice of the PAC members. Going forward we will continue to review and update as necessary (5) policies at each (bi-annual) PAC meeting. The Administrator in conjunction with the DOCS and the Governing Body will decide what those policies will be in advance of each PAC meeting.

- The Administrator, with input from the Board of Directors, and the PAC, shall develop/select a comprehensive Agency-wide evaluation tool that will provide for the collection of both subjective and objective data. This will be in place by May 1, 2013.
- Services and care will be evaluated for adequacy, effectiveness, efficiency and appropriateness.
- At least one (1) component of the evaluation process will be an objective and documented analysis of the Agency's compliance with the Medicare Conditions of Participation, as well as the regulations of any applicable regulatory agencies and/or applicable accrediting organizations.
- A written report shall be completed and submitted to the Administrator at least one (1) month prior to the end of the fiscal year.
- Aggregation and analysis of the employee evaluation data should be completed and submitted to the Administrator no later than one (1) month prior to the end of the fiscal year.
- Based on the results of the evaluations, a plan of correction, if appropriate, shall be developed and included in the Annual Agency Evaluation Report.
- The completed Agency Evaluation Report shall be submitted to the Board of Directors for review and ratification.

The Purpose will be to analyze the effectiveness of the organization's administrative practices, policies and procedures including personnel, financial and program administration policies.

The Administrator will be responsible for delegating and following up on this task for completion prior to November 30, 2013.

G245: 484.52 EVALUATION OF THE AGENCY'S PROGRAM

The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient.

- The Administrator, with input from the Board of Directors, and the PAC, shall develop/select a comprehensive Agency-wide evaluation tool that will provide for the collection of both subjective and objective data. This will be in place by May 1, 2013.
- Services and care will be evaluated for adequacy, effectiveness, efficiency and appropriateness.
- At least one (1) component of the evaluation process will be an objective and documented analysis of the Agency's compliance with the Medicare Conditions of Participation, as well as the regulations of any applicable regulatory agencies and/or applicable accrediting organizations.
- A written report shall be completed and submitted to the Administrator at least one (1) month prior to the end of the fiscal year.
- Aggregation and analysis of the employee evaluation data should be completed and submitted to the Administrator no later than one (1) month prior to the end of the fiscal year.
- Based on the results of the evaluations, a plan of correction, if appropriate, shall be developed and included in the Annual Agency Evaluation Report.
- The completed Agency Evaluation Report shall be submitted to the Board of Directors for review and ratification.

The Purpose will be to analyze the effectiveness of the organization's administrative practices, policies and procedures including personnel, financial and program administration policies.

The Administrator will be responsible for delegating and following up on this task for completion prior to November 30, 2013

G248: 484.52 (a) POLICY AND ADMINISTRATIVE REVIEW

As part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient.

The Agency conducts an annual comprehensive evaluation of the Agency's functioning and performance relative to its written mission, philosophy and goals.

Agency Administration and Board of Directors are committed to improving organizational performance and sustaining quality performance in the organization's governance, management and clinical processes with guidance from the PAC. Inherent in the Agency's leadership commitment to develop and implement a continuous effective performance improvement program is a commitment to plan, budget for and allocate adequate resources to sustain the performance improvement program.

The effectiveness of the Agency's administration and Board of Directors in implementing and sustaining an effective organization-wide performance improvement program is evaluated during the Agency annual evaluation.

Agency Administration and the Board of Directors participate in a variety of educational activities on a regular basis to learn about and maintain currency of knowledge relative to performance improvement principles and methodologies.

Agency Administration and the Board of Directors, in collaboration with appropriate Agency staff and the PAC, implements a planned, systematic, organization-wide approach to performance improvement, setting measurement priorities and ensuring that patient outcomes are continuously assessed and improved. Agency administration, upon approval of the Board of Directors, provides the following resources for assessing the organization's governance, managerial and clinical processes:

- Sufficient, appropriate staff, including management staff, to participate in performance improvement activities
- Adequate time for staff to participate in performance improvement activities
- Sufficient information systems and processes to support timely and efficient data collection, management and analysis

This is done to analyze the effectiveness of the organization's administrative practices, policies and procedures including personnel, financial and program administration policies as well as to determine if patient care that is appropriate, adequate, effective and efficient.

The Administrator will be responsible for delegating and following up on this task for completion prior to November 30, 2013

G 250: 484.52(b) CLINICAL RECORD REVIEW

At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement.

This opportunity allows the agency to upgrade its chart audit practices. A new Chart Audit tool is being developed and will be implemented as soon as it is finalized. This tool will have the ability to give numerical results to each and all portions of the agency's practice. Each section will allow the Governing Body and Professional Advisory Committee to see where the agency needs to be fine-tuned and changes made.

Previously, it was stated that the agency is currently implementing new computer software. The program when used to its ability hopefully will be able to indicate the changes that need to be made within the agency to provide the best care. Today, 3/29/13, the Director of Clinical Services (DCS) placed a telephone call to Axxess Software Company to ask if such a program was currently in the software. They offered the ability to ask for an upgrade to the program and that we should scan the Chart Audit tool and send it to them.

While waiting for this, the Quality Assurance Registered Nurse will implement the tool with the staff and work with them so a complete and authentic result might be obtained. This chart audit will occur on or before 4/15/13 for the first quarter of this year using 10% of current and closed charts being reviewed by the clinical staff, both employed by the agency and under contract. This will become a quarterly task so that the best practice for health care can be provided by the agency and the agency professionals.

A compilation of the results prepared by the QA RN will be made available for review by the Governing Body no later than 4/15/13.

(Please review the Clinical Record Audit Tool attached)

G 331: 484.55(a) (1) INITIAL ASSESSMENT VISIT

A Registered Nurse will conduct an initial assessment visit to determine the immediate care and support needs of the patient. The nurse will assess the patient eligibility for home health services including home bound status.

The plan of care will coincide with the patient's accurate health history as identified by physician visit notes or physician approved history and physical. All patient stated diagnoses or conditions not identified by the physician will be noted and sent to the patient's physician for verification and notification of symptoms. All pertinent diagnoses including mental status, types of services needed, durable medical equipment, frequency of visits outlined for each week of the episode, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items will be documented on the patients plan of care (485) for physician review and written approval by signature. A verbal order is received by the case manager at the generation of the plan of care (485) for physician approval and suggestions.

All care will be rendered according to the plan of care (485) and any deviation from the plan will be documented with physician orders to explain the deviation and necessary update to the plan of care. All clinicians involved in the case will receive written notification via Axxess messaging center at the time of deviation. No deviation of care will be permitted without verbal consent from the attending physician.

The plan of care (485) is reviewed by the case manager and involved clinicians, along with the Director of Quality Assurance on a regular bases to ensure that no care is being rendered outside of the plan of care without physician approval.

All pertinent diagnoses will have identified interventions and goals with expected outcomes documented on the plan of care. The physician will be notified of the patient's progress throughout the duration of care and will receive a written report for assessment of recertification or discharge orders prior to the patient being recertified or discharged. Each sixty day episode will include a sixty day case conference report detailing the physician on the patient's success or lack thereof for completion of the identified goals for the episode.

All clinicians responsible for completing the Oasis documentation at the start of care will receive Oasis training per CMS online module by 4/16/13. Training is inclusive to educate clinicians of proper documentation of homebound status, wound classification, staging, and care, patient DME needs, diagnostic coding, and other pertinent information.

G 337: 484.55© 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.

The agency has established an intake procedure which will ensure that referral paperwork includes a current list of medications, history and physical, and physician order. The Case Manager will review this paperwork prior to the first visit. At the start of care visit, the Case Manager will then compare the medication list with the medication bottles in the patient's home as well as review the list with the patient/caregiver. Any discrepancies will be noted and a medication clarification order will be sent to the physician.

Since the agency has now purchased a computer application that will not only do point-of-care documentation by the clinical staff but also to monitor patients' medications, including having available a complete list of medications including all over-the-counter medications. The computer software also provides a tool to help clinical staff monitor drug interactions and compatibility. This will become a permanent part of the clinical record.

Case managers will assess any medication changes during each skilled visit, document this assessment, and note any changes identified. This will ensure that a medication clarification order is generated and forwarded to the physician for signature. The system will allow this entire process to be completed during the skilled visit.

During this transition to the computer, of course the staff is unsure of its responsibilities and expectations. The agency is providing extensive training for the staff with individualized training for those staff members with less computer literacy. During this period the QA RN will enter physicians' orders for medications and treatments and provide communication notes to ensure staff awareness of any updates. This process will also ensure notes are included in the clinical record and that changes in wound care, medications, or changes to the plans of care are documented.

Currently, the Director of Clinical Services (DCS) has established an Excel Spreadsheet to track the plans of care to ensure they are timely and updated when necessary. This form will provide a quick reference to the Administrator, DCS, and QA RN so that physicians are notified of dressings ordered for wound care, medications, wound sizing, visit frequency, and other changes that will help patients maintain/regain their health status.

Under the direction of the DCS and Administrator supervision the QA RN will be responsible for this highly important part of Home Health Care. As above, the Excel spreadsheet was generated today (3/29/13). The review and transition to full computer use is and has been ongoing for about a month. On Tuesday, 4/9/13, there will be a daylong training session for the staff.

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the state licensure survey of your agency. Surveyors conducting the review were: Gary Guiles, RN, HFS, Team Leader Sylvia Creswell, LSW, HFS Susan Costa RN, HFS Libby Doane RN, BSN, HFS	N 000	 <i>Refer to P.O.C for G122 compliance date 4/17/13</i>	
N 001	03.07020.01. ADMIN.GOV.BODY 020. ADMINISTRATION - GOVERNING BODY. N001 01. Scope. The home health agency shall be organized under a governing body, which shall assume full legal responsibility for the conduct of the agency. This Rule is not met as evidenced by: Refer to G122 as it relates to the failure of the governing body to provide oversight to the agency.	N 001		
N 005	03.07020. ADMIN. GOV.BODY N005 03. Responsibilities. The governing body shall assume responsibility for: b. Appointing the group of professional personnel; meeting at least bi-annually. This Rule is not met as evidenced by: Refer to G130 as it relates to the failure of the governing body to appoint a group of professional	N 005		<i>Refer to POC for G130 compliance date 4/17/13</i>

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

MRL311

If continuation sheet 1 of 7

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N 005	Continued From page 1 personnel.	N 005		
N 047	03.07021.03.AMINISTRATOR N047 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: a. Organizing and coordinating administrative functions of the program, delegating duties, establishing a formal means of accountability on the part of staff members, and maintaining continuing liaison among the governing body, the group of professional personnel and the staff. This Rule is not met as evidenced by: Refer to G133 as it relates to the failure of the governing body to maintain continuing liaison among the governing body and the group of professional personnel.	N 047	<i>Refer to PDC for G133 compliance date 4/17/13</i>	
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 G144 as it relates to the failure of the	N 062	<i>Refer to PDC for G144 compliance date 4/17/13</i>	

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N 062	Continued From page 2 agency to ensure coordination of patient care occurred between all agency personnel caring for patients.	N 062		
N 119	03.07024.04.SK.NSG.SERV. N119 04. Supervisory Visits. A registered nurse or therapist makes a supervisory visit to the patient's residence at least every two (2) weeks, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are met. For patients who are receiving only home health aide services, a supervisory visit must be made at least every sixty (60) days. This Rule is not met as evidenced by: Refer to G228 as it relates to the failure of the agency to ensure aide supervisory visits were conducted at least every 2 weeks.	N 119	<i>Refer to POC for G228 Compliance date 4/17/13</i>	
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 G158 as it relates to the failure of the agency to ensure home health care followed a written plan of care.	N 152	<i>Refer to POC for G158 Compliance date 4/17/13</i>	

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N 153	Continued From page 3	N 153	<p><i>Refer to POC for G159 Compliance date 4/17/13</i></p>		
N 153	03.07030.PLAN OF CARE N153 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: a. All pertinent diagnoses; This Rule is not met as evidenced by: Refer to G159 as it relates to the failure of the agency to ensure home health care followed a written plan of care that included all pertinent diagnoses.	N 153			
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 G164 as it relates to the failure of the agency to ensure the professional staff promptly alerted the physician to changes that suggested a need to alter the plan of care.	N 172		<p><i>Refer to POC for G164 Compliance date 4/17/13</i></p>	
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	N 173	<p><i>Refer to POC for G165 Compliance date 4/17/13</i></p>		

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N 173	Continued From page 4 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 G165 as it relates to the failure of the agency to ensure treatments were administered by agency staff only as ordered by the physician.	N 173		
N 193	03.07040.AGENCY EVALUATION N193 040. AGENCY EVALUATION. A group of professional personnel, which includes at least one (1) physician, one (1) registered nurse, and with appropriate representation from other professional disciplines, establishes and annually reviews the agency's policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one (1) member of the group is neither an owner nor an employee of the agency. This Rule is not met as evidenced by: Refer to G242 as it relates to the failure of the agency to ensure an annual agency evaluation was conducted.	N 193	<i>Refer to POC for G242 Compliance date 4/17/13</i>	

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N 199	Continued From page 5	N 199		
N 199	<p>Criminal History and Background Check</p> <p>009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.</p> <p>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)</p> <p>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)</p> <p>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)</p> <p>This Rule is not met as evidenced by: Based on review of personnel records and staff interview, it was determined the agency failed to ensure completion of criminal background checks for 1 of 17 direct patient care staff (Staff #P), hired after October 2007. This had the potential to allow an employee who may have had disqualifying crimes access to patients. Findings</p>	N 199	<p>All direct patient access employees are required to have fingerprint and background checks cleared via IDAPA 16.05.06 on file before being allowed to do patient visits unsupervised. Telephone call with administrator 5-8-13 - Julie stated no staff would work unsupervised until background check complete. Clinical Director will monitor for compliance.</p> <p>5-8-13 11:30am [Signature]</p>	

Compliance date 4-28-13

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N 199	Continued From page 6 include: Personnel records were reviewed with the DCS on 3/06/12 at 10:00 AM. Employee files for patient care staff hired after October 2007 did not have evidence of a qualifying background check for Staff P, a PT Aide hired 11/19/12. The DCS confirmed the employee did not have Criminal background clearance from the Department of Health and Welfare. The agency did not ensure all direct care staff had completed a qualifying criminal history background check.	N 199		