

COPY



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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April 11, 2011

Todd Winder, Administrator
Oneida County Hospital Home Care
150 North 200 West
Malad City, ID 83252

RE: Oneida County Hospital Home Care, Provider #137077

Dear Mr. Winder:

This is to advise you of the findings of the Medicare/Licensure survey at Oneida County Hospital Home Care, which was concluded on March 30, 2011.

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

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

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

Todd Winder, Administrator
April 11, 2011
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **April 24, 2011**, and keep a copy for your records.

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

Sincerely,



TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srm
Enclosures

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

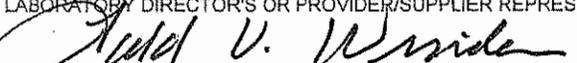
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137077	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/30/2011
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NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY HOSPITAL HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 200 WEST MALAD CITY, ID 83252
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G 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey of your agency. The surveyors conducting the survey were:</p> <p>Teresa Hamblin RN, MS, HFS, Team Leader Karen Robertson, RN, BS, HFS</p> <p>Acronyms used in this report include:</p> <p>DME - Durable Medical Equipment L - Liter mg - milligrams O2 - Oxygen POC - Plan of Care RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care</p>	G 000	<p>The statements made herein on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies or of the correctness of the conclusion set forth herein. The plan of correction is submitted as is requisite to continued program participation.</p>	
G 158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Care follows a written plan of care established 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, staff and patient interview, and home observation, it was determined the agency failed to ensure care followed the written POC as established by a physician for 2 of 11 patients (#1 and #6) whose records were reviewed. This had the potential to negatively impact quality and completeness of patient care. Findings include:</p> <p>1. Patient #1 was a 75 year old female admitted to the agency on 6/04/10 for care primarily related to diabetes. The "HOME HEALTH</p>	G 158	<p>G 158.OCH Home Care will continue to ensure that care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p><u>CORRECTIVE MEASURES</u> For all current and/or future patients, the plan of care has and will continue to be established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p>	5/23/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 4-18-11
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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.

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G 158	<p>Continued From page 1</p> <p>CERTIFICATION AND PLAN OF CARE," for certification period 1/30/11 to 3/30/11, included ADA diet as the nutritional requirement. The "SKILLED NURSING VISIT REPORT" documented Patient #1 was on a regular diet for the following dates: (for all notes except one on 3/16/11)</p> <p>1/25/11 at 11:40 AM 2/01/11 at 12:55 PM 2/10/11 at 2:30 PM 2/15/11 at 1:20 PM 2/22/11 at 12:40 PM 3/01/11 at 11:50 AM 3/08/11 at 11:25 AM 3/11/11 at 10:40 AM 3/14/11 at 12:35 PM 3/22/11 at 11:50 AM</p> <p>During a home visit on 3/29/11 from 1:40 PM - 2:10 PM, Patient #1 stated, "I just watch what I eat." She further stated both she and her spouse were diabetic, but neither calorie counted or followed any strict dietary guidelines.</p> <p>In an interview on 3/29/11 at 3:00 PM with Patient #1's RN, she stated her understanding was that Patient #1 was on a regular diet, but just adjusted as needed. The RN stated she was not aware Patient #1 had ADA diet on the POC.</p> <p>The agency did not follow the POC regarding nutritional requirements ordered.</p> <p>2. Patient #6 was a 69 year old male admitted to the agency on 1/14/11 for care primarily related to ulcer of the lower limb. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 3/15/11 to 5/13/11, included</p>	G 158	<p><u>MEASURES TO PREVENT REOCCURENCE</u></p> <p>All agency staff will be in serviced on those items where improvement is needed which includes ensuring that the POC will follow the nutritional requirements ordered and also follow the POC regarding the intervention to assess for depression. developed and implemented for each patient by all disciplines providing services for that patient</p> <p><u>MONITORING/ASSURANCE</u></p> <p>Home Health Director and agency staff will review that care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Monitoring results will be included in the quarterly Performance Improvement report.</p>	
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G 158	Continued From page 2 orders for SN to assess depression and need for intervention. The "SKILLED NURSING VISIT REPORT" did not document a depression or mood assessment for the following dates: 3/18/11 at 11:15 AM 3/21/11 at 11:20 AM 3/25/11 at 11:10 AM In an interview on 3/29/11 at 3:00 PM with Patient #6's RN, she agreed that depression was not consistently assessed. The agency did not follow the POC regarding the intervention to assess for depression.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the POC included all pertinent information for 7 of 11 patients (#2, #3, #4, #6, #7, #8, and #9) whose records were reviewed. This had the potential to result in incomplete or uncoordinated patient care. Findings include:	G 159		

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G 159	<p>Continued From page 3</p> <p>1. Patient #6 was a 69 year old male admitted to the agency on 1/14/11 for care primarily related to ulcer of the lower limb.</p> <p>a) The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 3/15/11 to 5/13/11, included medication orders for "Lidocaine 5% - patch 1 As Needed for pain." It did not include specific direction for when the patch should be removed and how often a patch could be placed.</p> <p>In an interview on 3/29/11 at 3:00 PM, the Director and Patient #6's RN agreed the Lidocaine order was unclear.</p> <p>b) The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 3/15/11 to 5/13/11, included medication orders for "OXYGEN 100% 4L GAS RESPIRATORY (As directed continuous)." The POC did not include oxygen supplies.</p> <p>During an interview on 3/29/11 at 2:00 PM, the Director explained the agency only included supplies on the POC the agency brought out to the home. She further explained the agency did not supply any DME and therefore did not include DME on the POC. It was her understanding this was the correct way to complete the POC.</p> <p>c) On 3/21/11 at 11:20 AM in the "SKILLED NURSING VISIT REPORT," the RN had documented "continues to use barrier cream." The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 3/15/11 to 5/13/11, did not include barrier cream.</p> <p>In an interview on 3/29/11 at 3:00 PM, the RN</p>	G 159	<p>G 159 OCH Home Care will continue to ensure the plan of care developed in consultation with the agency staff covers all pertinent diagnosis, 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.</p> <p><u>CORRECTIVE MEASURES</u> For all current and/or future patients, the above items have and will continue to be included in the plan of care.</p> <p><u>MEASURES TO PREVENT REOCCURENCE</u> All agency staff will be in-serviced on those items where improvement is</p>	5/23/11

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G 159	<p>Continued From page 4</p> <p>stated Patient #6 rarely uses the barrier cream, though he does have some at home.</p> <p>The agency did not include the barrier cream on Patient #6's POC.</p> <p>2. Patient #8 was an 87 year old female admitted to the agency on 12/28/10 for care primarily related to chronic lymphoid leukemia. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 12/28/10 to 2/25/11, included an order for OXYGEN 100% 2 GAS INHALATION As Directed continuously via nasal cannula. The POC did not include oxygen supplies.</p> <p>During an interview on 3/29/11 at 2:00 PM, the Director explained the agency only included supplies on the POC the agency brought out to the home. She further explained the agency did not supply any DME and therefore did not include DME on the POC. It was her understanding this was the correct way to complete the POC.</p> <p>The agency did not include the oxygen supplies on Patient #8's POC.</p> <p>3. Patient #9 was a 72 year old male admitted to the agency on 1/14/11 for care primarily related to aftercare of a hip replacement. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 1/14/11 to 3/14/11, did not include TED hose.</p> <p>A "TRANSFER/DISCHARGE ORDERS" form, dated 1/14/11 at 11:00 AM and signed by the physician included orders for Patient #9 to wear TED hose for 6 weeks.</p>	G 159	<p>needed which includes ensuring that the POC includes all pertinent information including complete medication orders and all DME and supplies needed will be included on the plan of care.</p> <p><u>MONITORING /ASSURANCE</u> Home Health Director and agency staff will review plan of care for completeness of all pertinent information prior to being sent to physician for signature. Monitoring results will be included in the quarterly Performance Improvement report.</p>	

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G 159	<p>Continued From page 5</p> <p>During an interview on 3/29/11 at 2:00 PM, the Director explained the agency only included supplies on the POC the agency brought out to the home. She further explained the agency did not supply any DME and therefore did not include DME on the POC. It was her understanding this was the correct way to complete the POC.</p> <p>The agency did not include all pertinent information in the POC.</p> <p>4. Patient #2 was a 69 year old female who was admitted to the home health agency on 3/16/11 for care after back surgery. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 3/16/11 to 5/14/11, included orders for oxygen. Oxygen equipment was not included on the plan of care.</p> <p>During a home visit on 3/30/11 between 1:10 PM and 2:00 PM, Patient #2 was observed to wear a lumbar support back brace and TED hose. Neither items were included in the plan of care.</p> <p>During an interview on 3/29/11 at 2:00 PM, the Director of Home Health explained the agency only included supplies on the POC the agency brought out to the home. She further explained the agency did not supply any DME and therefore did not include DME on the POC. It was her understanding this was the correct way to complete the POC.</p> <p>The written plan of care did not include equipment and supplies relevant to Patient #2's plan of care.</p> <p>5. Patient #4 was an 91 year old female who was admitted to the home health agency on 10/13/10 for care primarily related to an ulcer on her ankle.</p>	G 159		

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G 159	<p>Continued From page 6</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 2/10/10 to 4/10/11, included orders for continuous oxygen at 2 liters per nasal canula. Oxygen equipment was not included on the POC.</p> <p>Patient #4 was visited and observed in her home receiving home health aide services on 3/30/11 between 11:45 AM and 12:30 PM. Patient #4 was wearing braces on her right and left lower legs and walking with a walker. A bath bench was in her tub.</p> <p>During the visit, the home health aide stated Patient #4 uses her walker and the bath bench. She removes the leg braces prior to the bath. She stated Patient #4 was not allowed to put any weight on one of her legs, so she put the leg braces back on after the bath, before Patient #4 stood up. The POC did not include a bath bench or leg braces as equipment relevant to Patient #4's POC.</p> <p>During an interview on 3/29/11 at 2:00 PM, the Director of Home Health explained the agency only included supplies on the POC the agency brought out to the home. She further explained the agency did not supply any DME and therefore did not include DME on the POC. It was her understanding this was the correct way to complete the POC.</p> <p>The plan of care did not include relevant equipment and safety measures.</p> <p>6. Patient #3 was a 97 year old female who was admitted to the home health agency on 2/16/11 for care primarily related to an open wound on her leg. The "HOME HEALTH CERTIFICATION AND</p>	G 159		

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G 159	Continued From page 7 PLAN OF CARE" for certification period 2/16/11 to 4/16/11 contained two sets of oxygen orders: Oxygen 100% 2 liters as directed intermittently at night via nasal canula," and Oxygen 99% 2 liters as needed. The orders orders were not consistent. During an interview on 3/29/11 at 2:00 PM, the Director of Home Health reviewed Patient #3's record and confirmed the inconsistent oxygen entries. The plan of care included inconsistent information. 7. Patient #7 was an 84 year old female who was admitted to the home health agency on 12/10/10 for care primarily related to congestive heart failure. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 2/08/11 to 4/08/11, included orders for continuous oxygen. Oxygen equipment was not included in the POC. During an interview on 3/29/11 at 2:00 PM, the Director of Home Health explained the agency only included supplies on the POC the agency brought out to the home. She further explained the agency did not supply any DME and therefore did not include DME on the POC. It was her understanding this was the correct way to complete the POC. The plan of care did not include equipment relevant to Patient #7's plan of care.	G 159		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the	G 164		

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G 164	<p>Continued From page 8</p> <p>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 record review and staff interview, it was determined the agency failed to alert the physician to changes that suggested a need to alter the plan of care in 3 of 6 patients (#4, #6 and #8) who had oxygen orders whose records were reviewed. This resulted in outdated plans of care. Findings include:</p> <p>1. Patient #6 was a 69 year old male admitted to the agency on 1/14/11 for care primarily related to ulcer of the lower limb. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 3/15/11 to 5/13/11, listed oxygen as continuous.</p> <p>On the "SKILLED NURSING VISIT REPORT," oxygen saturations were documented as being taken on room air for the dates of 3/18/11 at 11:15 AM and 3/21/11 at 11:20 AM.</p> <p>In an interview on 3/29/11 at 3:00 PM, Patient #6's RN confirmed that the oxygen saturations were taken on room air and stated Patient #6 was actually using oxygen as needed during the day and continuous at night. The RN stated she was unaware that the POC still listed oxygen as continuous and agreed the POC should have been updated.</p> <p>The agency did not alert the physician and update the POC.</p> <p>2. Patient #8 was an 87 year old female admitted to the agency on 12/28/10 for care primarily</p>	G 164	<p>G 164 OCH Home Care will continue to ensure that agency professional staffs promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p><u>CORRECTIVE MEASURES</u> For all current and/or future patients, agency professional staff have and will continue to promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p><u>MEASURES TO PREVENT REOCCURENCE</u> All agency staff will be in-serviced on those items where improvement is needed which includes ensuring that staff promptly alert the physician to any changes in the POC that suggest a need to alter the plan of care including Oxygen changes.</p>	5/23/11

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G 164	<p>Continued From page 9</p> <p>related to chronic lymphoid leukemia. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 12/28/10 to 2/25/11, listed oxygen as continuous.</p> <p>In an interview on 3/29/11 at 3:00 PM, Patient #8's RN stated Patient #8 was actually using oxygen as needed during the day and continuous at night. The RN stated she thought the oxygen was listed as intermittent on the POC and so had not contacted the physician.</p> <p>The agency did not alert the physician and update the POC.</p> <p>3. Patient #4 was an 91 year old female who was admitted to the home health agency on 10/13/10 for care primarily related to an ulcer on her ankle. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 2/10/10 to 4/10/11, included continuous oxygen at 2 liters per nasal canula.</p> <p>During a home visit on 3/30/11 at 11:45 AM to 12:30 PM, Patient #4 was observed and interviewed. She was not using oxygen or wearing oxygen equipment.</p> <p>The RN who conducted the medication review for the most current certification period was interviewed on 3/29/11 at 2:00 PM. She stated Patient #4 did not use oxygen continuously. She stated she did not realize the plan of care said continuous and would need to update the plan of care to reflect prn use.</p> <p>Nursing staff did not alert the physician to Patient #4's oxygen usage which suggested a need to alter the plan of care.</p>	G 164	<p><u>MONITORING/ASSURANCE</u></p> <p>Home Health Director and agency staff will review plans of care and notes to ensure that the staffs promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>Monitoring results will be included in the quarterly Performance Improvement report.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY HOSPITAL HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 200 WEST MALAD CITY, ID 83252		
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G 224	<p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE</p> <p>Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on record review, staff interview, patient interview, and observation during a home visit, it was determined the agency failed to ensure the RN provided complete written patient care instructions for the home health aide for 1 of 1 patient (#4) who was observed in a home health setting receiving home health aide services. This had the potential to interfere with patient safety and coordination of patient care. Findings include:</p> <p>Patient #4 was an 91 year old female who was admitted to the home health agency on 10/13/10 for care primarily related to an ankle ulcer. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 2/10/11 to 4/10/11, included medication orders for continuous oxygen at 2 liters per nasal cannula and home health aide services 1 time per week for 1 week, and then 3 times per week for 8 weeks.</p> <p>Surveyors visited and observed Patient #4 in her home on 3/30/11 between 11:45 AM and 12:30 PM while the home health aide provided services. Patient #4 was observed to be wearing braces on her right and left lower legs and using a walker to ambulate from the kitchen to the bathroom for her bath. A bath bench was present in her tub.</p>	G 224	<p>G 224 <i>OCH Home Care will continue to ensure that written patient care instructions for the home health aide must be prepared by the registered nurse of other professional who is responsible for the supervision of the home health aide.</i></p> <p><u>CORRECTIVE MEASURES</u> For all current and or future patients receiving home health care aides agency professional staffs have and will continue to ensure that written patient care instructions for the home health aide are prepared by the registered nurse of other professional who is responsible for the supervision of the home health aide. These written patient care instructions are to include guidance related to the bath bench, braces, walker, O2 and other pertinent information</p>	5/23/11

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G 224	Continued From page 11 Patient #4 was not observed to wear oxygen during the visit. During the visit, the home health aide confirmed Patient #4 regularly used a walker and the bath bench. She further explained she removed Patient #4's leg braces prior to assisting her with a bath. She stated Patient #4 was not allowed to put any weight on one of her legs, so she put the leg braces back on after the bath, before Patient #4 stood up. The "HHA Care Plan," dated 2/09/11, included assignments for the aide to give Patient #4 a tub shower, assist with ambulation. The POC did not include guidance about whether Patient #4 should use oxygen during bathing, use a walker, use a bath bench, take off braces, or avoid standing on the one leg without a brace. The Director of Home Health was interviewed on 3/30/11 at 2:45 PM. She reviewed Patient #4's record and confirmed the aide POC did not and should have included guidance related to the bath bench, leg braces, walker, and oxygen.	G 224	<u>MEASURES TO PREVENT REOCCURENCE</u> All agency staff will in in serviced on "assignment and duties of the home health aide" and that plans of care provide specific instructions for all the duties to be performed. <u>MONITORING/ASSURANCE</u> The HH director and agency staff will review all home health aide care plans for completeness at the start of care and (if applicable) at recertification. Monitoring results will be included in the quarterly Performance Improvement report.	
G 337	The written aide POC was incomplete. 484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on record review, patient interview, and	G 337		

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G 337	<p>Continued From page 12</p> <p>staff interview, it was determined the agency failed to ensure comprehensive drug assessments were completed for 2 of 3 patients (#2 and #4) whom surveyors visited in their homes. This resulted in an inability to fully assess medications for potential noncompliance with drug therapy or side effects or ineffectiveness. Findings include:</p> <p>1. Patient #4 was an 91 year old female who was admitted to the home health agency on 10/13/10 for care primarily related to an ulcer on her ankle. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 2/10/10 to 4/10/11, included the following medication orders:</p> <p>> continuous oxygen at 2 liters per nasal canula, > Ultram tablets 50 mg 1 tab as needed > Colace 100 mg twice a day.</p> <p>During a home visit on 3/30/11 at 11:45 AM to 12:30 PM, Patient #4 was observed and interviewed. She was not wearing oxygen (it was ordered continuous). She stated she had not taken ultram since prior to the initiation of home health services. She stated she only occasionally uses Colace (instead of twice per day as ordered).</p> <p>The RN who conducted the medication review for the most current certification period was interviewed on 3/29/11 at 2:00 PM. She stated Patient #4 did not use oxygen continuously. She stated she did not realize the plan of care said continuous and would need to update the plan of care to reflect prn use. She stated she did not specifically go through all of the medications at the recertification visit, but instead asked Patient</p>	G 337	<p>G 337 OCH Home Care will complete a comprehensive assessment which will 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> <p><u>CORRECTIVE MEASURES</u> For all current and/or future patients, agency professional staffs have and will continue to complete a comprehensive assessment which will include a review of all medications the patient is currently using. The current medication sheet will be reviewed and revised if necessary to assist with compliance</p>	5/23/11

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G 337	<p>Continued From page 13</p> <p>#4 if there had been any changes in her medications.</p> <p>The medications in the home did not match the plan of care. The drug review was not comprehensive.</p> <p>2. Patient #2 was a 69 year old female who was admitted to the home health agency on 3/16/11 for care after back surgery. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 3/16/11 to 5/14/11, included medication orders for:</p> <ul style="list-style-type: none"> > Colace 100 MG 1 tab twice a day, > Celexa tablets 20 mg 1 tab daily, and > Methadone Hydrochloride tablets 5 mg 4 times per day. <p>Patient #2 was interviewed during a home visit on 3/30/11 between 1:10 PM and 2:00 PM. She stated she did not take Colace or Celexa and had not since coming home from the hospital. She stated she took a 10 mg dose of Methadone Hydrochloride 4 times per day rather than 5 mg.</p> <p>The RN who conducted the medication review was interviewed on 3/30/11 at 2:00. She stated she reviewed all the medications and they must have been in the home at the time of the review.</p> <p>The medications in the home did not match the plan of care.</p>	G 337	<p><u>MEASURES TO PREVENT REOCCURENCE</u></p> <p>Agency personnel will be in serviced on completion of accurate and complete medication sheet.</p> <p><u>MONITORING/ASSURANCE</u></p> <p>The HH director and agency staff will monitor medication sheets/485's for complete and accurate information.</p> <p>Monitoring results will be included in the quarterly Performance Improvement report</p>	

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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 federal tag G158 as it relates to the failure of the agency to ensure care followed a written a plan of care.	N 152	<p>The statements made herein on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies or of the correctness of the conclusion set forth herein. The plan of correction is submitted as is requisite to continued program participation.</p> <p>N 152 Refer to tag G 158</p> <p>N 155 Refer to tag G 159</p> <p>N 160 OCH will ensure that 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 nutritional requirements.</p>	
N 155	03.07030. PLAN OF CARE N155 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: c. Types of services and equipment required; This Rule is not met as evidenced by: Refer to federal tag G159 as it relates to the failure of the agency to ensure the POC included all services and equipment required.	N 155		5/23/11
N 160	03.07030.PLAN OF CARE N160 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	N 160		

Bureau of Facility Standards <i>Jedid V. Wisnie</i> LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE CEO	(X6) DATE 4-18-11
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N 160	<p>Continued From page 1 includes:</p> <p>h. Nutritional requirements;</p> <p>This Rule is not met as evidenced by: Based on record review and staff and patient interview it was determined the agency failed the ensure the nutritional care plan of 1 of 11 patients (Patient #1) whose records were reviewed, was followed. Findings include:</p> <p>Patient #1 was a 75 year old female admitted to the agency on 6/04/10 for care primarily related to diabetes. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 1/30/11 to 3/30/11, included ADA diet as the nutritional requirement. The "SKILLED NURSING VISIT REPORT" documented Patient #1 was on a regular diet for the following dates: (for all notes except one on 3/16/11)</p> <p>1/25/11 at 11:40 AM 2/01/11 at 12:55 PM 2/10/11 at 2:30 PM 2/15/11 at 1:20 PM 2/22/11 at 12:40 PM 3/01/11 at 11:50 AM 3/08/11 at 11:25 AM 3/11/11 at 10:40 AM 3/14/11 at 12:35 PM 3/22/11 at 11:50 AM</p> <p>During a home visit, Patient #1 stated "I just watch what I eat." She further stated both she and her spouse were diabetic, but neither calorie counted or followed any strict dietary guidelines.</p> <p>In an interview on 3/29/11 at 3:00 PM with Patient #1's RN, she stated her understanding was that</p>	N 160	<p><u>CORRECTIVE MEASURES</u> For all current and/or future patients, the plan of care has and will continue to be developed and implemented for each patient by all disciplines providing services for that patient.</p> <p><u>MEASURES TO PREVENT REOCCURENCE</u> All agency staff will in serviced on those items where improvement is needed which includes ensuring that the POC will follow the nutritional requirements developed and implemented for each patient by all disciplines providing services for that patient.</p> <p><u>MONITORING/ASSURANCE</u> Home Health Director and agency staff will review plans of care to ensure that care follows a written plan of care and includes correct nutritional requirements.</p>	

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N 160	Continued From page 2 Patient #1 was on a regular diet, but just adjusted as needed. The RN stated she was not aware Patient #1 had ADA diet on the POC. The agency did not follow the POC regarding nutritional requirements ordered.	N 160	N161 Refer to tag G 159 N 172 Refer to tag G 164 N 173 Refer to tag G 337	
N 161	03.07030.PLAN OF CARE N161 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: i. Medication and treatment orders; This Rule is not met as evidenced by: Refer to federal tag G159, example #1, as it relates to the failure of the agency to ensure the POC included clear directions regarding the use of medications.	N 161		
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 federal tag G164 as it relates to the failure of the agency to ensure the physician was alerted promptly to situations which may warrant a change in a patient's plan of care.	N 172		

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N 173	Continued From page 3	N 173			
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to federal tag G337 as it relates to the failure of the agency to ensure all patient medications were identified.	N 173			