IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
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May 22, 2012

Dextral Miles, Administrator
Western Visiting Nurses Inc
1400 Benton
Idaho Falls, ID 83401

RE: Western Visiting Nurses Inc, Provider #137025

Dear Mr. Miles:

This is to advise you of the findings of the Medicare/Licensure survey at Western Visiting Nurses Inc, which was concluded on May 10, 2012.

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

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

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

After you have completed your Plan of Correction, return the original to this office by **June 3, 2012**, and keep a copy for your records.

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

Sincerely,

KAREN DEWEY
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

KD/srm
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137025	A. BUILDING _____ B. WING _____	05/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN VISITING NURSES INC	1400 BENTON IDAHO FALLS, ID 83401

(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 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your Home Health Agency. The following surveyors conducted the survey: Karen Dewey, RN, BSN, HFS, Team Leader Teresa Hamblin, RN, MS, HFS Acronyms used in this report include: AFO - Ankle-Foot Orthotic CHF - Congestive Heart Failure DME - Durable Medical Equipment G-tube - Gastrostomy Tube LPN - Licensed Practical Nurse mg - milligram MSW - Medical Social Worker OT - Occupational Therapy PO - By Mouth POC - Plan of Care PT - Physical Therapy RN - Registered Nurse ST - Speech Therapy	G 000	See attached Plan of Correction RECEIVED MAY 30 2012 FACILITY STANDARDS	6/29/12
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on record review, staff interview, and family interview, it was determined the agency failed to ensure effective coordination of care for 2 of 7 patients (#6 and #12) who were observed	G 143		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tami L Z Banda	Administrator	05/29/12

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

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G 143	Continued From page 1 during home visits. This had the potential to result in unmet patient needs. Findings include: Patient #12 and Patient #6 were 3 year old twins admitted to the agency on 3/08/12 for OT services. They both had diagnoses of developmental delay and prematurity. In addition, Patient #12 had diagnoses of brain bleed and a disorder of the digestive tract that required Patient #12 to have G-tube feedings. An Occupational Therapist documented the start-of-care assessments on 3/08/12 on a form titled "OCCUPATIONAL THERAPY COMPREHENSIVE ADULT ASSESSMENT." Patient #6's assessment, dated 3/08/12 documented he was receiving ST through another agency. Patient #12's assessment documented she was receiving ST and PT through the other agency. It also documented Patient #12 was experiencing pain, manifested by grimacing, moaning/crying, irritability, tense, screaming. It stated she had a "short gut" and diaper rash and she "completely shuts down when (she) poops, can't walk." A home visit was conducted on 5/09/12 between 11:00 AM and 11:45 AM. During the visit, Patient 12's mother was interviewed. She reported another home health agency was seeing Patient #12 and Patient #6 for ST services. She stated the kids were supposed to receive PT services and that had not happened. When asked if nursing services were provided, she stated she wasn't sure, but a nurse or some other caregiver came and checked Patient #12 and took her vital signs on occasion. She also stated a nurse from Patient #12's school kept calling her because	G 143	See attached Plan of Correction	6/29/12

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G 143	Continued From page 2 Patient #12's diaper rash was so bad. The mother said she wished she had a social worker to be an advocate for her because people did not understand Patient #12's medical issues and blamed her for the diaper rash. There was no documentation of coordination with the other home health agency or elsewhere in the community to ensure patient needs had been met. During the home visit, the Occupational Therapist was also interviewed. When asked if she had any contact with the other home health agency that was providing care to Patient #12 and #6, she responded "not related to the twins" (Patient #12 and #6). The RN Supervisor and Clinical Director were interviewed on 5/10/12 at 9:55 AM. The RN Supervisor confirmed the lack of coordination and expressed the intention to contact the other agency to see what services were involved and how their agency could assist in meeting the needs of the twins.	G 143	See attached Plan of correction	6/29/12
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review, staff interview, and observation during a home visit, it was determined the agency failed to ensure care followed the written POC as ordered by a	G 158		

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G 158	Continued From page 3 physician for 5 of 12 sample patients (#1, #7, #8, #9, and #10) whose records were reviewed. This had the potential to negatively impact patient outcomes. Findings include: 1. A policy titled, "ADMISSION OF PATIENTS," reviewed 2011, stated, "If therapy is ordered, the initial therapy visit must be made within 48 hours of the referral or the date specified by the physician for start of care. If this is not possible, the physician must be notified and the physician contact noted in the patient's medical record." The following are examples of initial therapy visits that were not conducted in a timely manner per agency policy: a. Patient #1 was a 76 year old male admitted to the agency on 11/03/11 for care primarily related to a pressure ulcer. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 11/03/12 to 1/01/12, included orders for one time PT and OT evaluation visits. However, an initial PT visit was not done until 11/08/11 and an initial OT visit was not done until 11/15/11. The Clinical Director and RN Supervisor were interviewed together on 5/09/12 at 2:45 PM. They reviewed the medical record and stated the initial PT and OT visits were not conducted within 48 hours of the referral as per agency policy. They also stated the physician was not notified of the delays per agency expectation. b. Patient #7 was a 69 year old female admitted to the agency on 4/27/12 for care primarily related to diabetes. The "HOME HEALTH	G 158	See attached Plan of Correction	6/29/12

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G 158	Continued From page 4 CERTIFICATION AND PLAN OF CARE," for the certification period 4/27/12 to 6/25/12, included orders for a one time PT evaluation visit. However, the initial PT visit was not done until 5/07/12. The Clinical Director and RN Supervisor were interviewed together on 5/09/12 at 2:45 PM. They reviewed the medical record and stated the initial PT visit was not conducted within 48 hours of the referral as per agency policy. They also stated the physician was not notified of the delay per agency expectation. c. Patient #8 was an 82 year old female admitted to the agency on 2/23/12 for care primarily related to depression. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 2/23/12 to 4/22/12, included orders for one time PT and OT evaluation visits. However, an initial PT visit was not done until 3/14/12 and an initial OT visit was not done until 3/16/12. The Clinical Director and RN Supervisor were interviewed together on 5/09/12 at 2:45 PM. They reviewed the medical record and stated the initial PT and OT visits were not conducted within 48 hours of the referral as per agency policy. They also stated the physician was not notified of the delays per agency expectation. d. Patient #10 was an 87 year old female admitted to the agency on 2/20/12 for care primarily related to adult failure to thrive. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 2/20/12 to 4/19/12, included orders for a one time PT	G 158	See Attached Plan of Correction	6/29/12

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G 158	Continued From page 5 evaluation visit. However, an initial PT visit was not done until 2/27/12. The Clinical Director and RN Supervisor were interviewed together on 5/09/12 at 2:45 PM. They reviewed the medical record and stated the initial PT visit was not conducted within 48 hours of the referral as per agency policy. They also stated the physician was not notified of the delay per agency expectation. The agency did not ensure the initial therapy visits followed the POC per agency expectation. 2. The following are examples of the POC not being followed as evidenced by missed and extra visits by agency staff: a. Patient #8 was an 82 year old female admitted to the agency on 2/23/12 for care primarily related to depression. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 2/23/12 to 4/22/12, included orders for a one time MSW evaluation visit. An MSW evaluation visit was conducted 2/27/12. The "Medical Social Work Plan of Treatment," dated 2/27/12 and signed by the physician 3/15/12, included orders for one MSW visit a week for four weeks. However, except for the evaluation visit, no MSW visits were conducted for the certification period. The RN Supervisor was interviewed 5/10/12 at 10:00 AM. She reviewed the medical record and stated there were no MSW visits after the evaluation visit on 2/27/12. She stated the physician was not informed of the missed visits.	G 158	See attached Plan of Correction	6/29/12

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G 158	Continued From page 6 b. Patient #9 was a 7 year old male admitted to the agency on 7/18/07 for care primarily related to congenital anomalies. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 4/22/12 to 6/20/12, included orders for OT visits one time a week for nine weeks. However, no visits were made the weeks of 4/23/12 and 4/30/12. The RN Supervisor was interviewed 5/10/12 at 10:00 AM. She reviewed the medical record and stated there were no OT visits for the weeks of 4/23/12 and 4/30/12. She also stated the physician was not informed of the missed visits. c. Patient #10 was an 87 year old female admitted to the agency on 2/20/12 for care primarily related to adult failure to thrive. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 2/20/12 to 4/19/12, included orders for home health aide visits five times the first week, then three visits for eight weeks. However, five home health aide visits were conducted the week of 2/27/12, instead of the three ordered. On 3/02/12, the physician ordered home health aide visits to increase to every day effective 3/05/12. However, five home health aide visits were conducted the week of 4/09/12, instead of the seven ordered. Four home health aide visits were conducted the week of 4/16/12, instead of the seven ordered. The Clinical Director and the RN Supervisor were interviewed 5/09/12 at 2:45 PM. They reviewed the medical record and stated there were extra and missed home health aide visits, as noted	G 158	See attached Plan of Correction	6/29/12

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G 158	Continued From page 7 above. The agency did not ensure visits were made per the POC.	G 158	See attached Plan of Correction	6/29/12
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 6 of 12 patients (#2, #3, #4, #5, #10, and #12) whose records were reviewed. This had the potential to interfere with continuity and completeness of patient care. Findings include: 1. Patient #4 was a 72 year old wheelchair-bound female who was admitted to the agency on 4/09/12 for care that related to intractable edema of the lower legs, CHF, diabetic neuropathy, and dermatitis. The "COMPREHENSIVE ADULT NURSING ASSESSMENT," dated 4/09/12, included the following assessment information: Patient #4 reported weighing 300 pounds and had +3 pitting edema of lower extremities. She used 3 liters of oxygen and a glucometer for assessing	G 159		

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G 159	Continued From page 8 blood sugars. The assessment data did not indicate whether the oxygen was used on a continuous or intermittent basis. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE, for the certification period 4/09/12 to 6/07/12, did not include the need to weigh Patient #4 even though she had edema and CHF. It did not include oxygen equipment or a glucometer as relevant DME/supplies even though she was on oxygen and was diabetic. The medication list included an order for Carvedilol (a beta blocker used to treat CHF). It did not state the dose or frequency of the medication. The RN Supervisor was interviewed on 5/10/12 at 9:30 AM. She reviewed Patient #4's record and confirmed the findings. Patient #4's plan of care was incomplete. 2. Patient #12 was a 3 year old female who was admitted to the agency on 3/08/12 for OT services. An Occupational Therapist documented the start-of-care assessment, dated 3/08/12, on a form titled "OCCUPATIONAL THERAPY COMPREHENSIVE ADULT ASSESSMENT." The assessment documented Patient #12 was experiencing pain, as manifested by grimacing, moaning/crying, irritability, tense, and screaming. It stated she had a "short gut" and diaper rash and she "completely shuts down when poops, can't walk." The "HOME HEALTH CERTIFICATION AND PLAN OF CARE, " for the certification period 3/08/12 to 5/06/12, did not address the pain or diaper rash.	G 159	See attached Plan of Correction	6/29/12

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G 159	Continued From page 9 The RN Supervisor and Clinical Director were interviewed on 5/10/12 at 9:55 AM. The RN Supervisor reviewed Patient #12's record and confirmed the issue had not been addressed. Patient #12's plan of care was incomplete. 3. Patient #2 was a 51 year old diabetic female who was admitted to the agency on 11/18/04 primarily for allergy injections. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 4/10/12 to 6/08/12, included orders for twice weekly allergy injections. It also included orders for monitoring blood sugars. It included the following DME/Supplies: dressing supplies, syringes, sharps container, and venipuncture supplies. It did not include a blood glucose testing machine or gloves for giving the injections. Patient #2 was visited in her home on 5/08/12 between 9:45 AM and 10:45 AM. When asked if the agency staff drew blood on occasion, she stated any blood draws were done in her physician's office. A blood glucose machine was observed in the home. The nurse was observed to use gloves while giving Patient #2 her allergy injection. The RN Supervisor was interviewed on 5/10/12 at 10:10 AM. She reviewed Patient #2's record and confirmed the DME/Supplies needed updating to include the blood glucose testing machine and gloves and to discontinue the venipuncture supplies. The plan of care did not include current supplies and equipment needed for Patient #2's care.	G 159	See Attached Plan of Correction	6/29/12

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G 159	Continued From page 10 4. Patient #3 was an 89 year old female who was admitted to the agency on 2/09/12. She had diagnoses that included osteoarthrosis, celiac disease, and diabetes. The "RECERTIFICATION ASSESSMENT," dated 4/18/12, indicated Patient #3 had a diagnosis of celiac disease. During a home visit on 5/08/12 between 11:05 AM and 12:00 PM, Patient #3 was observed to be sitting in a Power Lift chair wearing oxygen with a portable tank at her side. She stated she used a wheelchair to get around, had a ramp in the garage to exit the home, and a grabber to help her reach items in the house. When asked if she were on any special diet, Patient #3 said she had celiac disease and was on a gluten-free diet. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 4/19/12 to 6/17/12, stated nutritional requirements were "controlled carbohydrate." It did not indicate Patient #3 was on a gluten-free diet, consistent with celiac disease. It included medication orders for Lomotil 2.5 mg PO. It did not state the frequency of the medication. It included orders for oxygen at 2 liters at night and as needed during the day. The need for oxygen equipment was not included on the POC. The POC did not include equipment/supplies observed in the patient's home during a home visit on 5/08/12, including a power lift chair, a grabber, and a wheelchair. The RN Supervisor and Clinical Director were interviewed on 5/10/12 at 9:10 AM. The RN Supervisor reviewed Patient #3's record and confirmed the POC should have included the	G 159	See attached Plan of Correction	6/29/12

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G 159	Continued From page 11 gluten-free diet and the supplies/DME referenced. She also confirmed the Lomotil prescription was incomplete. Patient #3's plan of care did not include all relevant DME/supplies, appropriate diet information, or complete medication orders. 5. Patient #5 was a 32 year old female admitted to the agency on 5/15/09 for care primarily related to cerebral palsy. A home visit was conducted on 5/09/12 from 10:30 AM to 11:25 AM to observe PT. During the visit, Patient #5 was observed to use a wheelchair. She and the Physical Therapist stated she also used crutches, soft wrist braces when using the crutches, AFO leg braces when in her wheelchair not doing therapy, and a shower chair. However, the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 2/29/12 to 4/28/12 and 4/29/12 to 6/27/12, did not include the AFO leg braces or the shower chair. The Physical Therapist was interviewed immediately following the home visit. He stated he had forgotten to include the AFO leg braces and the shower chair on Patient #5's POC. The agency did not include pertinent DME on Patient #5's POC. 6. Patient #10 was an 82 year old female admitted to the agency on 2/20/12 for care primarily related to adult failure to thrive.	G 159	See attached Plan of Correction	6/29/12

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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)	(X5) COMPLETION DATE
G 159	Continued From page 12 A home visit was conducted on 5/09/12 from 8:35 AM to 10:05 AM to observe home health aide services. During the visit, Patient #10 was observed to use a shower bench and grab bars in the bathroom. However, the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 2/20/12 to 4/19/12 and 4/20/12 to 6/18/12, did not include the shower bench or grab bars. The Clinical Director and RN Supervisor were interviewed on 5/09/12 at 2:45 PM. They reviewed the medical record and stated the POC did not include the shower bench or the grab bars. The agency did not include pertinent DME on Patient #10's POC.	G 159	See attached Plan of Correction	6/29/12
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the registered nurse made necessary revisions to the plan of care for 1 of 7 patients (#4) who were observed during home visits. This resulted in a nurse giving dietary advice in contrast to physician order. Findings include Patient #4 was a 72 year old female who used a wheelchair for ambulation and was admitted to the agency on 4/09/12 for care that related to	G 173		

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	137025	A. BUILDING _____ B. WING _____	05/10/2012

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G 173	Continued From page 13 intractable edema of the lower legs, CHF, diabetic neuropathy, and dermatitis. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 4/09/12 to 6/07/12, included orders for a "controlled carbohydrate diet." An RN visit note, dated 4/25/12 documented Patient #4 reported seeing her physician the day before and having her diet changed to a low sodium diet with a fluid restriction of 24 ounces. There was no documentation to indicate the diet was clarified with the physician and the plan of care revised to reflect the change in diet. An LPN visit note, dated 4/29/12 at 11:30 AM documented encouraging Patient #4 to drink fluids. This education was inconsistent with the new diet. The RN Supervisor was interviewed on 5/10/12 at 9:30 AM. She reviewed Patient #4's record and confirmed the plan of care had not been revised to reflect the new diet. The plan of care was not revised to reflect dietary changes. This resulted in inappropriate teaching on the part of another staff member.	G 173	See attached Plan of Correction	6/29/12
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the	G 176		

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G 176	Continued From page 14 registered nurse informed the physician of patient conditions requiring reporting for 2 of 8 patients (#1 and #4) who received skilled nursing services whose records were reviewed. This interfered with physician awareness of patient conditions that may have suggested a need to alter the plan of care. Findings include: 1. Patient #4 was a 72 year old female who use a wheelchair for ambulation and was admitted to the agency on 4/09/12 for care that related to intractable edema of the lower legs, CHF, diabetic neuropathy, and dermatitis. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 4/09/12 to 6/07/12, included orders to evaluate cardiopulmonary and diabetic status. The POC included goals for blood glucose in the 80-120 range and pulse in the 60-100 range. Nursing notes indicated Patient #4's blood glucose levels were above the goal range of 80-120, as follows: 178 at 4/10/12 at 2:15 PM 157 at 4/13/12 at 2:15 PM 157 at 4/14/12 at 2:00 PM 152 at 4/15/12 at 3:30 PM 154 on 4/17/12 at 1:15 PM 148 on 4/20/12 at 5:00 PM 143 on 4/25/12 at 1:00 PM 150 on 4/26/12 at 2:15 PM 188 on 4/27/12 at 12:00 PM 163 on 4/30/12 at 6:15 PM Nursing notes indicated Patient #4's pulse was below the goal range of 60-100, as follows:	G 176	See attached Plan of Correction	6/29/12

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G 176	Continued From page 15 58 on 5/03/12 at 12:45 PM 59 on 4/27/12 at 12:00 PM 58 on 4/26/12 at 2:15 PM 57 on 4/25/12 at 1:00 PM 56 on 4/24/12 at 12:45 PM There was no documentation to indicate the blood glucose levels or pulses had been reported to the physician. The RN Supervisor and Clinical Director were interviewed on 5/10/12 at 9:30 AM. The RN Supervisor reviewed Patient #4's record and confirmed there was no evidence the results had been reported to the physician. The registered nurse did not report blood glucose levels and pulses that fell outside the range indicated on the physician's plan of care. 2. Patient #1 was a 76 year old male admitted to the agency on 11/03/11 for care primarily related to a pressure ulcer. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 11/03/12 to 1/01/12, included an order to monitor blood glucose. The POC included the goal for blood glucose in the 80-120 range. Aide notes indicated Patient #1's blood glucose levels were above the goal range of 80-120 in the following examples: 228 on 11/04/11 at 12:30 PM. 199 on 11/06/11 at 11:30 AM. 249 on 11/08/11 at 10:32 AM. 268 on 11/15/11 at 10:15 AM. 178 on 11/17/11 at 10:30 AM.	G 176	See attached Plan of correction	6/29/12

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G 176	Continued From page 16 148 on 11/19/11 at 10:15 AM. There was no documentation to indicate the blood glucose levels had been reported to the physician. The RN Supervisor was interviewed on 5/10/12 at 10:00 AM. She reviewed the medical record and confirmed there was no evidence the blood glucose levels had been reported to the physician. The agency did not ensure blood glucoses that fell outside the range indicated on Patient #1's POC were reported to the physician.	G 176	See attached Plan of Correction	6/29/12
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the registered nurse provided written instructions for the home health aide there were complete and clear for 2 of 5 patients (#3 and #10) who received aide services whose records were reviewed. This had the potential to negatively impact quality, completeness, and coordination of patient care. Findings include: 1. Patient #3 was an 89 year old female who was admitted to the agency on 2/09/12. She had	G 224		

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G 224	Continued From page 17 diagnoses that included osteoarthrosis, celiac disease, and diabetes. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 4/19/12 to 6/17/12, included orders for twice weekly aide services. During a home visit on 5/08/12 between 11:05 AM and 12:00 PM, an aide was observed providing care to Patient #3. A bath chair was observed in the shower. After a shower, Patient #3 was observed to be sitting in a Power Lift chair wearing oxygen with a portable tank at her side. "AIDE INSTRUCTIONS," dated 4/18/12, did not address oxygen, a bath chair, or a Power Lift chair. The RN Supervisor and Clinical Director were interviewed on 5/10/12 at 9:10 AM. The RN Supervisor reviewed Patient #3's record and confirmed the aide plan of care did not address the need for oxygen use or include the equipment. Patient care instructions were incomplete. 2. Patient #10 was an 87 year old female admitted to the agency on 2/20/12 for care primarily related to adult failure to thrive. A home visit was conducted on 5/09/12 from 8:35 AM to 10:05 AM to observe home health aide services. During the visit, Patient #10 was observed to use a shower bench and grab bars in the bathroom. However, "AIDE INSTRUCTIONS," dated and	G 224	See attached Plan of Correction	6/29/12

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G 224	Continued From page 18 signed by the RN on 4/18/12, did not address the use of the shower bench or grab bars. The Clinical Director and RN Supervisor were interviewed on 5/09/12 at 2:45 PM. They reviewed the medical record and stated the "AIDE INSTRUCTIONS" did not include the shower bench or the grab bars. Patient care instructions were incomplete.	G 224	See attached Plan of Correction	6/29/12
G 225	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the home health aide provided services in accordance with the plan of care for 4 of 5 patients (#1, #3, #10, and #11) who received aide services whose records were reviewed. This resulted in potentially significant findings not being reported to the RN. Findings include: 1. Patient #11 was a 99 year old female who was admitted to the agency on 5/02/07. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification periods 2/05/12 to 4/04/12 and 4/05/12 to 6/03/12, included orders for aide services 5 visits per week for personal care, ADL assistance, light housekeeping, meal preparation and medication reminders/assistance. "AIDE INSTRUCTIONS,"	G 225		

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G 225	Continued From page 19 dated 2/01/12 and signed by a RN, included instructions for the aide to report confusion, anxiety, and combativeness and pain greater than 4 on a scale of 0-10. Fifteen of fifteen aide visit notes reviewed, did not address confusion, anxiety, combativeness, or pain. These included visits in 2012 on 2/06, 2/07, 2/08, 2/10, 2/11, 2/12, 2/13,2/14, 2/15, 2/17, 2/18, 2/20, 2/22, 2/24, 2/25, and 2/27. The RN Supervisor and Clinical Director were interviewed on 5/10/12 at 9:50 AM. The RN Supervisor reviewed Patient #11's record and confirmed there was no documentation these areas had been evaluated. The aide care plan was not followed. 2. Patient #3 was an 89 year old female who was admitted to the agency on 2/09/12. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 4/19/12 to 6/17/12, included orders for twice weekly aide services. "AIDE INSTRUCTIONS," dated 4/18/12, included instructions for the aide to test Patient #3's blood glucose level each visit and report blood glucose levels that fell outside of the 80-120 range. It also included instructions to take Patient #3's pulse each visit and report results that fell outside of the 60-100 range. An aide note, dated 4/19/12 at 3:30 PM did not include a blood sugar result or a comment to explain why it was not taken. An aide note, dated 5/01/12 at 11:15 AM included a pulse of "56." There was no evidence it had been reported to the nurse.	G 225	See attached Plan of Correction	6/29/12

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G 225	Continued From page 20 The RN Supervisor and Clinical Director were interviewed on 5/10/12 at 9:10 AM. The RN Supervisor reviewed Patient #3's record and confirmed a blood glucose level was missing on 4/19/12 and evidence of reporting was missing. The aide care plan was not followed. 3. Patient #1 was a 76 year old male admitted to the agency on 11/03/11 for care primarily related to a pressure ulcer. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 11/03/12 to 1/01/12, included an order to monitor blood glucose. The POC included the goal for blood glucose in the 80-120 range. The "AIDE INSTRUCTIONS," dated 11/03/11 and signed by the RN, instructed the home health aide to report to the RN if vital signs were "outside ranges," which included blood glucose levels. "AIDE NOTES" indicated Patient #1's blood glucose level was above the goal range of 80-120 in the following examples: 228 on 11/04/11 at 12:30 PM. 199 on 11/06/11 at 11:30 AM. 249 on 11/08/11 at 10:32 AM. 268 on 11/15/11 at 10:15 AM. 178 on 11/17/11 at 10:30 AM. 148 on 11/19/11 at 10:15 AM. There was no documentation to indicate the blood glucose results had been reported to the RN. The Clinical Director and RN Supervisor were	G 225	See attached Plan of Correction	6/29/12

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G 225	Continued From page 21 interviewed on 5/09/12 at 2:45 PM. They reviewed the medical record and confirmed there was no evidence the blood glucose results had been reported to the RN. The agency did not ensure blood glucose levels that fell outside the range indicated on Patient #1's POC were reported to the RN. 4. Patient #10 was an 87 year old female admitted to the agency on 2/20/12 for care primarily related to adult failure to thrive. "AIDE INSTRUCTIONS," dated and signed by the RN on 2/20/12, included direction to "prompt to take meds Pill in pink box before meal white box after." Patient #10's son stated he had to watch the aides to make sure they gave Patient #10 the right medication. He said they were always asking him to clarify the medication instructions. He stated he spoke with the RN about the aides' confusion and she said she would speak with the physician and update the paperwork to be less confusing. He stated he had not seen any change in the aides' behavior since the RN had updated the paperwork. The "AIDE INSTRUCTIONS" were on a form that was divided in two with the instructions on one side and the "AIDE NOTES" on the other. Once the instructions were completed by the RN, copies were made and placed in the home binder for the home health aides to document their cares under "AIDE NOTES." The updated "AIDE INSTRUCTIONS," dated and signed by the RN on 4/18/12, included instructions to "med assist Prompt to take meds." This allowed all medications to be taken at the same time.	G 225	See attached Plan of Correction	6/29/12

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G 225	Continued From page 22 However, between 4/18/12 and 5/01/12 aides continued to document care provided on the form which included the 2/20/12 "AIDE INSTRUCTIONS". The updated instructions were not used by the aides until 5/02/12. The Clinical Director and RN Supervisor were interviewed on 5/09/12 at 2:45 PM. They stated Patient #10's medication orders had changed to show the meds could be given at the same time. They reviewed the medical record and stated they did not know why the home health aides had not received the updated instructions until 5/02/12. They stated the aides had not been providing care per the aide POC. The agency did not ensure home health aides followed the "AIDE INSTRUCTIONS."	G 225	See Attached Plan of Correction	6/29/12
G 336	484.55(b)(3) COMPLETION OF THE COMPREHENSIVE ASSESSMENT When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician, a physical therapist, speech-language pathologist or occupational therapist may complete the comprehensive assessment, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. The occupational therapist may complete the comprehensive assessment if the need for occupational therapy establishes program eligibility. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the agency failed to ensure assessments were comprehensive for 4	G 336		

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G 336	Continued From page 23 of 4 patients (#5, #6, #9, and #12) who had assessments performed by therapy staff. This resulted in incomplete assessments and had the potential to interfere with development of the plan of care to meet patients' needs. Findings include: 1. An agency policy, "COMPREHENSIVE ASSESSMENT AND OASIS DATA COLLECTION," dated 2011, was reviewed. It stated, "Each patient must receive, and a home health agency must provide, a specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social and discharge planning needs." This policy was not followed as evidenced by: a. Patient #12 and Patient #6 were 3 year old twins admitted to the agency on 3/08/12 for OT services. They both had diagnoses of developmental delay and prematurity. In addition, Patient #12 had diagnoses of brain bleed and a disorder of the digestive tract that required Patient #12 to have G-tube feedings. An OT documented the start-of-care assessments for Patient #6 and Patient #12 on 3/08/12 on a form titled "OCCUPATIONAL THERAPY COMPREHENSIVE ADULT ASSESSMENT." The assessments did not include vital signs or cardiopulmonary assessment, such as listening to heart and lungs.	G 336	See Attached Plan of Correction	6/29/12

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G 336	Continued From page 24 The RN Supervisor and Clinical Director were interviewed on 5/10/12 at 9:55 AM. The RN Supervisor confirmed vital signs and cardiopulmonary assessment was missing. The assessments of Patient #6 and Patient #12 were not comprehensive. b. Patient #5 was a 32 year old female admitted to the agency on 5/15/19 for care primarily related to cerebral palsy. A physical therapist documented the recertification assessment on 4/25/12 on a form titled, "PHYSICAL THERAPY RECERTIFICATION/FOLLOW-UP ASSESSMENT." The assessment did not include vital signs. The Clinical Director and RN Supervisor were interviewed on 5/09/12 at 2:45 PM. They confirmed vital signs were missing from the assessment. Patient #5's assessment was incomplete. c. Patient #9 was a 7 year old male admitted to the agency on 7/18/07 for care primarily related to congenital anomalies. An occupational therapist documented a recertification assessment on 4/20/12 on a form titled, "PHYSICAL THERAPY RECERTIFICATION/FOLLOW-UP ASSESSMENT." The assessment did not include an integumentary or elimination status, or vital signs.	G 336	See attached Plan of Correction	6/29/12

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G 336	Continued From page 25 The Clinical Director and RN Supervisor were interviewed on 5/09/12 at 2:45 PM. They confirmed integumentary and elimination status, and vital signs were missing from the assessment. Patient #9's assessment was incomplete.	G 336	See attached Plan of Correction	6/29/12
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on record review, policy review, observations during home visits, staff interview and patient interview, it was determined the agency failed to ensure the drug review in the home was comprehensive for 4 of 7 patients (#3, #5, #6, and #12) who were visited in their homes. This had the potential to interfere with identification of side effects or adverse effects of medications or evaluation of effectiveness of the medications. Findings include: An agency policy, "COMPREHENSIVE ASSESSMENT AND OASIS DATA COLLECTION," dated 2011, included information on the drug regimen review. It stated, "The comprehensive assessment includes a review of all medications the patient is currently using. This allows staff to identify any potential adverse effects and drug reactions, including ineffective	G 337		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137025	A. BUILDING _____ B. WING _____	05/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN VISITING NURSES INC	1400 BENTON IDAHO FALLS, ID 83401

(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 337	Continued From page 26 drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy." The drug regimen review was not comprehensive in the examples that follow: 1. Patient #3 was an 89 year old female who was admitted to the agency on 2/09/12. She had diagnoses that included osteoarthrosis, celiac disease, and diabetes. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 4/19/12 to 6/17/12, included (but were not limited to) medication orders for Lomotil 2.5 mg PO, Furosemide (Lasix) 40 mg PO every day as needed, and K Dur 20 mg every day. A home visit was made on 5/08/12 between 11:05 AM and 12:00 PM. Patient #3 was asked how she took her medication. She stated the Lomotil, Furosemide and K Dur were all used as needed. She explained that if she did not need the Furosemide that day then she did not take the K Dur because the purpose of the K Dur was to replace the potassium lost from the Furosemide. There was no clarification in the record regarding whether the K Dur 20 mg was to be taken every day regardless of whether she took the Furosemide, consistent with the POC, or whether the K Dur was to be taken only on the days she took the Furosemide, consistent with Patient #3's understanding. The RN Supervisor and Clinical Director were interviewed on 5/10/12 at 9:10 AM. The RN Supervisor reviewed Patient #3's record and	G 337	See Attached Plan of Correction	6/29/12

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G 337	Continued From page 27 confirmed the Furosemide was ordered on an as-needed basis. She stated she was not sure if it was the physician's intention Patient #3 took the K Dur every day or just on the days the Patient #3 took the Furosemide. She acknowledged, it should have been clarified. She also confirmed the Lomotil should have included instructions to be used on an as needed basis. The medication review was incomplete. 2. Patient #12 and Patient #6 were 3 year old twins admitted to the agency on 3/08/12 for OT services. They both had diagnoses of developmental delay and prematurity. In addition, Patient #12 had diagnoses of brain bleed and a disorder of the digestive tract that required Patient #12 to have G-tube feedings. A home visit was conducted on 5/09/12 between 11:00 AM and 11:45 AM. During the visit, Patient 12's mother was interviewed. When asked about the medications the twins took, she referenced both of them being on Albuterol .05 every 4 hours as needed for breathing treatments. She stated the kids had been on the medication "for years." When asked when they last used the medication, she stated Patient #6 had bronchitis a couple weeks prior and had to be on it at that time. This medication was not listed on the drug review or "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification periods 3/08/12 to 5/06/12 or 5/07/12 to 7/09/12. The RN Supervisor and Clinical Director were interviewed on 5/10/12 at 9:55 AM. The RN Supervisor confirmed the medication was not	G 337	See attached Plan of Correction	6/29/12

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G 337	Continued From page 28 included in the drug review. The medication review was incomplete. 3. Patient #5 was a 32 year old female admitted to the agency on 5/15/09 for care primarily related to cerebral palsy. She lived in a 24-hour care home. A home visit was conducted on 5/09/12 from 10:30 AM to 11:25 AM to observe PT. Patient #5's home medication profile was reviewed. It was found that the home medication profile did not match the medications listed on the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 4/29/12 to 6/27/12. The POC listed Tramadol 50 mg PO every 4 hours. The home medication profile, updated 12/27/11, listed Tramadol 50 mg PO three times a day and also included Ibuprofen 600 mg every 4-6 hours as needed. The Physical Therapist was interviewed immediately following the home visit. He stated he had not recently reviewed Patient #5's home medication profile. He stated the care home's manager usually informed him if there were changes and she had not informed him of the Tramadol and Ibuprofen changes. The agency did not ensure a comprehensive medication assessment was conducted.	G 337	See Attached Plan of Correction	6/29/12

Bureau of Facility Standards

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	OAS001680	A. BUILDING _____ B. WING _____	05/10/2012

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the state licensure survey of your home health agency. Surveyors conducting the survey were: Karen Robertson, RN, BS, HFS Teresa Hamblin, RN, MS, HFS The following abbreviations are used in the report: AFO - Ankle-Foot Orthotic CHF - Congestive Heart Failure DME - Durable Medical Equipment mg - milligram OT - Occupational Therapy PO - By Mouth POC - Plan of Care PT - Physical Therapy RN - Registered Nurse	N 000	See Attached Plan of Correction RECEIVED MAY 30 2012 FACILITY STANDARDS	6/29/12
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 G143.	N 062		
N 094	03.07024. SK. NSG. SERV.	N 094		

Bureau of Facility Standards

Tami Mc Randa — TITLE: Administrator — (X6) DATE: 05/29/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 094	Continued From page 1 N094 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: b. Initiates the plan of care and makes necessary revisions; This Rule is not met as evidenced by: Refer to G173.	N 094	See Attached Plan of Correction	6/29/12
N 098	03.07024. SK. NSG. SERV. N098 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: f. Informs the physician and other personnel of changes in the patient's condition and needs; This Rule is not met as evidenced by: Refer to G176.	N 098		
N 122	03.07024.SK.NSG.SERV. N122 05. Training, Assignment and Instruction of A Home Health Aide. c. Written instructions for home care, including specific	N 122		

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N 122	Continued From page 2 exercises, are prepared by a registered nurse or therapist as appropriate. This Rule is not met as evidenced by: Refer to G224.	N 122	See attached Plan of Correction	6/29/12
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.	N 152		
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: Based on record review, observation, patient and staff interview, it was determined the agency failed to ensure the plan of care included all equipment for 5 of 12 patients (#2, #3, #4, #5, and #10) whose records were reviewed. This	N 155		

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N 155	Continued From page 3 had the potential to interfere with continuity and completeness of patient care. Findings include: 1. Patient #4 was a 72 year old wheelchair-bound female who was admitted to the agency on 4/09/12 for care that related to intractable edema of the lower legs, CHF, diabetic neuropathy, and dermatitis. The "COMPREHENSIVE ADULT NURSING ASSESSMENT," dated 4/09/12, included the following assessment information: Patient #4 reported weighing 300 pounds and had +3 pitting edema of lower extremities. She used 3 liters of oxygen and a glucometer for assessing blood sugars. The assessment data did not indicate whether the oxygen was used on a continuous or intermittent basis. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE, for the certification period 4/09/12 to 6/07/12, did not include oxygen equipment or a glucometer as relevant DME/supplies even though she was on oxygen and was diabetic. The RN Supervisor was interviewed on 5/10/12 at 9:30 AM. She reviewed Patient #4's record and confirmed the findings. Patient #4's plan of care did not include pertinent DME/supplies. 2. Patient #2 was a 51 year old diabetic female who was admitted to the agency on 11/18/04 primarily for allergy injections. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 4/10/12 to 6/08/12, included orders for twice weekly allergy injections. It also included orders for monitoring blood sugars. It included the following DME/Supplies: dressing supplies, syringes, sharps container,	N 155	See Attached Plan of Correction	6/29/12

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N 155	Continued From page 4 and venipuncture supplies. It did not include a blood glucose testing machine or gloves for giving the injections. Patient #2 was visited in her home on 5/08/12 between 9:45 AM and 10:45 AM. When asked if the agency staff drew blood on occasion, she stated any blood draws were done in her physician's office. A blood glucose machine was observed in the home. The nurse was observed to use gloves while giving Patient #2 her allergy injection. The RN Supervisor was interviewed on 5/10/12 at 10:10 AM. She reviewed Patient #2's record and confirmed the DME/Supplies needed updating to include the blood glucose testing machine and gloves and to discontinue the venipuncture supplies. The plan of care did not include current supplies and equipment needed for Patient #2's care. 3. Patient #3 was an 89 year old female who was admitted to the agency on 2/09/12. She had diagnoses that included osteoarthrosis, celiac disease, and diabetes. During a home visit on 5/08/12 between 11:05 AM and 12:00 PM, Patient #3 was observed to be sitting in a Power Lift chair wearing oxygen with a portable tank at her side. She stated she used a wheelchair to get around, had a ramp in the garage to exit the home, and a grabber to help her reach items in the house. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 4/19/12 to 6/17/12, included orders for oxygen at 2 liters at night and as needed during the day.	N 155	See Attached Plan of Correction	6/29/12

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N 155	Continued From page 5 The need for oxygen equipment was not included on the POC. The POC did not include equipment/supplies observed in the patient's home during a home visit on 5/08/12, including a power lift chair, a grabber, and a wheelchair. The RN Supervisor and Clinical Director were interviewed on 5/10/12 at 9:10 AM. The RN Supervisor reviewed Patient #3's record and confirmed the POC should have included the supplies/DME referenced. Patient #3's plan of care did not include all relevant DME/supplies. 4. Patient #5 was a 32 year old female admitted to the agency on 5/15/09 for care primarily related to cerebral palsy. A home visit was conducted on 5/09/12 from 10:30 AM to 11:25 AM to observe PT. During the visit, Patient #5 was observed to use a wheelchair. She and the Physical Therapist stated she also used crutches, soft wrist braces when using the crutches, AFO leg braces when in her wheelchair not doing therapy, and a shower chair. However, the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 2/29/12 to 4/28/12 and 4/29/12 to 6/27/12, did not include the AFO leg braces or the shower chair. The Physical Therapist was interviewed immediately following the home visit. He stated he had forgotten to include the AFO leg braces and the shower chair on Patient #5's POC. The agency did not include pertinent DME on Patient #5's POC.	N 155	See Attached Plan of Correction	6/29/12

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N 155	Continued From page 6 5. Patient #10 was an 82 year old female admitted to the agency on 2/20/12 for care primarily related to adult failure to thrive. A home visit was conducted on 5/09/12 from 8:35 AM to 10:05 AM to observe home health aide services. During the visit, Patient #10 was observed to use a shower bench and grab bars in the bathroom. However, the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 2/20/12 to 4/19/12 and 4/20/12 to 6/18/12, did not include the shower bench or grab bars. The Clinical Director and RN Supervisor were interviewed on 5/09/12 at 2:45 PM. They reviewed the medical record and stated the POC did not include the shower bench or the grab bars. The agency did not include pertinent DME on Patient #10's POC.	N 155	See attached Plan of Correction	6/29/12
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 includes: h. Nutritional requirements; This Rule is not met as evidenced by: Based on record review, observation, patient and staff interview, it was determined the agency	N 160		

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N 160	Continued From page 7 failed to ensure the plan of care included nutritional requirments for 1 of 12 patients (#3) whose records were reviewed. This had the potential to interfere with continuity and completeness of patient care. Findings include: Patient #3 was an 89 year old female who was admitted to the agency on 2/09/12. She had diagnoses that included osteoarthrosis, celiac disease, and diabetes. The "RECERTIFICATION ASSESSMENT," dated 4/18/12, indicated Patient #3 had a diagnosis of celiac disease. During a home visit on 5/08/12 between 11:05 AM and 12:00 PM, Patient #3 was asked if she were on any special diet, Patient #3 said she had celiac disease and was on a gluten-free diet. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 4/19/12 to 6/17/12, stated nutritional requirements were "controlled carbohydrate." It did not indicate Patient #3 was on a gluten-free diet, consistent with celiac disease. The RN Supervisor and Clinical Director were interviewed on 5/10/12 at 9:10 AM. The RN Supervisor reviewed Patient #3's record and confirmed the POC should have included the gluten-free diet. Patient #3's plan of care did not include the appropriate diet information.	N 160	See attached Plan of Correction	6/29/12
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	N 161		

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N 161	Continued From page 8 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: Based on record review, observation, patient and staff interview, it was determined the agency failed to ensure the plan of care included treatments and medications for 3 of 12 patients (#3, #4, and #12) whose records were reviewed. This had the potential to interfere with continuity and completeness of patient care. Findings include: 1. Patient #4 was a 72 year old wheelchair-bound female who was admitted to the agency on 4/09/12 for care that related to intractable edema of the lower legs, CHF, diabetic neuropathy, and dermatitis. The "COMPREHENSIVE ADULT NURSING ASSESSMENT," dated 4/09/12, included the following assessment information: Patient #4 reported weighing 300 pounds and had +3 pitting edema of lower extremities. She used 3 liters of oxygen. The assessment data did not indicate whether the oxygen was used on a continuous or intermittent basis. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE, for the certification period 4/09/12 to 6/07/12, did not include the need to weigh Patient #4 even though she had edema and CHF. The medication list included an order for Carvedilol (a beta blocker used to treat CHF). It did not state the dose or frequency of the medication. The RN Supervisor was interviewed on 5/10/12 at	N 161	See attached Plan of Correction	6/29/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 161	Continued From page 9 9:30 AM. She reviewed Patient #4's record and confirmed the findings. Patient #4's plan of care was incomplete. 2. Patient #12 was a 3 year old female who was admitted to the agency on 3/08/12 for OT services. An Occupational Therapist documented the start-of-care assessment, dated 3/08/12, on a form titled "OCCUPATIONAL THERAPY COMPREHENSIVE ADULT ASSESSMENT." The assessment documented Patient #12 was experiencing pain, as manifested by grimacing, moaning/crying, irritability, tense, and screaming. It stated she had a "short gut" and diaper rash and she "completely shuts down when poops, can't walk." The "HOME HEALTH CERTIFICATION AND PLAN OF CARE, " for the certification period 3/08/12 to 5/06/12, did not address the pain or diaper rash. The RN Supervisor and Clinical Director were interviewed on 5/10/12 at 9:55 AM. The RN Supervisor reviewed Patient #12's record and confirmed the issue had not been addressed. Patient #12's plan of care did not include the diaper rash as a diagnosis. 3. Patient #3 was an 89 year old female who was admitted to the agency on 2/09/12. She had diagnoses that included osteoarthrosis, celiac disease, and diabetes. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 4/19/12 to 6/17/12, stated included medication orders for Lomotil 2.5 mg PO. It did not state the frequency of the medication.	N 161	See Attached Plan of Correction	6/29/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001680	A. BUILDING _____ B. WING _____	05/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN VISITING NURSES INC	1400 BENTON IDAHO FALLS, ID 83401

(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) COMPLETE DATE
N 161	Continued From page 10 The RN Supervisor and Clinical Director were interviewed on 5/10/12 at 9:10 AM. The RN Supervisor reviewed Patient #3's record and confirmed the Lomotil prescription was incomplete. Patient #3's plan of care did not include complete medication orders.	N 161	See attached plan of correction	6/29/12
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 G337.	N 173		

PLAN OF CORRECTION

Western Visiting Nurses, Inc. has a 29-year history of compliance with regulation in the provision of Home Health Care to Medicare and Medicaid beneficiaries in Idaho. The management team at Western Visiting Nurses, Inc. is committed to improving the professionalism of its employees and contractors and to returning its documentation of care to former levels.

We take the following actions to ensure compliance with the Conditions of Participation with respect to the deficiencies cited following the Facility Survey ending May 10, 2012. The Board of Directors has met and empowers Ms. Tami Miles-Banda, MPH, Administrator, Mr. Dextral Miles, MBA, (Former Administrator) Vice President of the Board of Directors, and Mr. Daniel W. Knight, RN, Clinical Director, to assure that the following actions are completed by June 29, 2012.

General Systemic Improvements:

1. Contact with outside entities caring for our patients were made by Ms. Marie Kraus, RN Supervisor, to review our patients we shared with them during the week following the Survey.
2. Form design revisions were well under-way in the week following the Survey. This includes the Aide Instruction Sheet, the Therapy Evaluation Form, and the Skilled Nurses Notes.
3. Policy changes have already been made to revise therapy evaluation standards, handling delays in making therapy visits, in reviewing medications, and in making the Plan of Care development process more comprehensive.
4. A memorandum was distributed on May 29, 2012 to the RN's, LPN's, and CNA's on staff, as well as the Medical Record Technicians, describing the survey deficiencies and our proposed remedies. The memorandum discussed every item brought up by the survey team (without identifying individual patient names) and will serve as an immediate reminder of proper Home Health practice, as well as the beginnings of an agenda for the education sessions we plan to provide before June 29, 2012. These educational sessions will focus on the revised procedures and requirements of this Plan of Correction.

Corrective actions had already begun before the surveyors left the building.

Specific Plan of Correction (Federal and State tags included):

G-143, 484.14(g) COORDINATION OF PATIENT SERVICES
N-062, 03.07021 ADMINISTRATOR
CORRECTIVE ACTIONS TO BE TAKEN:

1. When WVNI receives information that a patient is cared for by another agency or community entity, the agency will obtain the patient's signature on the HIPAA agreement which will allow our staff to share information regarding the patient. The patient's responsible family members, may sign the form if the patient cannot.

2. The RN Case Coordinators and Therapists will receive training to coordinate activities with other agencies providing services to their client and to document the coordination in our patient record.

DESCRIPTION OF PROCESS IMPROVEMENT:

1. Our HIPAA forms will be revised to identify other agencies or entities providing care to the patient on the occasion of the first evaluation visit. Whenever an agency employee or contractor learns that another agency or community entity is involved in providing care to the patient they will add the entity to the HIPAA form and acquire a patient signature to allow us to coordinate with that entity.
2. A Medical Record Technician will monitor the handling of these HIPAA forms to assure they are filled out properly.
3. Training sessions for the RN's and Contracting Therapists will emphasize the importance of coordinating care between all caregivers in any patient's home. The training will include a discussion of documentation requirements to assure this information is in the patient's medical record.

PROCEDURES TO IMPLEMENT PLANNED ACTION:

1. The Clinical Director will modify existing agency forms and arrange for printing and distribution of the revised form which will be used in obtaining HIPAA agreement with other entities and the patient.
2. The Clinical Director and the Administrator will instruct the RN Case Coordinators and the Therapists in coordination procedures and in documenting coordination properly.
3. The Clinical Director will instruct the Medical Record Technicians in procedures to monitor compliance with this procedure.

MONITORING AND TRACKING PROCEDURES:

1. Medical Record Technicians will review the patient record to assure that both the HIPAA form and the coordination is being documented properly.
2. The RN Supervisor will be the primary Administrative point of contact with other entities and agencies providing care to our patients and will review the components of their care with the RN Case Coordinators or the Therapists assigned to the patient, on at least a monthly basis.

COMPLETION DATE: 6/29/2012

PERSON(S) RESPONSIBLE TO SEE ACTION IS CARRIED OUT: Daniel Knight, RN, Clinical Director, Marie Kraus, RN Supervisor, and Kathy Anderson, LPN, Medical Record Technician.

G-158, 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER
N-152, 03.07030.01 PLAN OF CARE

CORRECTIVE ACTIONS TO BE TAKEN:

1. The policy of WVNI has been modified to include patient contact parameters following therapy referral, extend the time frame to make the first therapy visit, and to further define the requirement to document notification of the physician as to the exact planned date of the first therapy visit.
2. Training sessions for the RN's and Contracting Therapists will emphasize the importance of notifying the physician properly of any delay in starting care or delay in making an initial visit. The new policy of WVNI will be explained to the participants and agency form modifications will be discussed.

3. Medical Record Technicians will review the patient record to assure that the time frame between Therapy referral and the initial visit is within agency policy and that documentation exists of changes or delays in visits.
4. The Clinical Director will modify the Fax MD Notification form to allow the therapists and RN Case Coordinators to properly document notification of the physician of visit delays or missed visits.
5. A tracking mechanism will be developed with the Medical Record Technicians to track evaluation visits as well as Medicare required follow-up evaluations. These visit targets will be calendared and the Medical Record Technician will provide reminders to the Therapists to assure that visits occur according to the Plan of Care.

DESCRIPTION OF PROCESS IMPROVEMENT:

1. Both Therapists and RN Case Coordinators will be trained in accurately projecting visit dates and parameters and in documenting delays and changes in visits.
2. Calendaring and tracking of visit planning will require the Medical Record Technician to remind the therapist of planned visits and to inform the RN Supervisor of any therapist who does not perform a visit on time to assure the MD is properly notified.

PROCEDURES TO IMPLEMENT PLANNED ACTION:

1. Appropriate forms will be modified and reproduced by the Clinical Director.
2. Training for therapists and RN Case Coordinators will take place to assure they understand the new requirements.
3. The Medical Record Technician will calendar and remind therapists of evaluation visits and inform the RN Supervisor of any problems so that she can coordinate with the therapists and the MD.

MONITORING AND TRACKING PROCEDURES:

1. The Medical Records Technician will calendar and track the therapy evaluation visits and remind the therapists in her phone contacts with them.
2. The RN Supervisor and the Clinical Director will supervise the activities of the Medical Record Technician to assure that proper calendaring and tracking is taking place.

COMPLETION DATE: 6/29/2012

PERSON(S) RESPONSIBLE TO SEE ACTION IS CARRIED OUT: Daniel Knight, RN, Clinical Director, Marie Kraus, RN Supervisor, and Kathy Anderson, LPN, Medical Record Technician.

G-159, 484.18(a) PLAN OF CARE
G-173, 484.30(a) DUTIES OF THE REGISTERED NURSE
N-094, 03.08024 SKILLED NURSING SERVICES
N-155, 03.07030 PLAN OF CARE
N-160, 03.07030 PLAN OF CARE
N-161, 03.07030 PLAN OF CARE

CORRECTIVE ACTIONS TO BE TAKEN:

1. Existing agency forms will be properly utilized to assure that all DME, medical supplies, and medications are captured on the initial assessment by the RN Case Coordinator or the Therapist making the assessment. This information will flow through to a revised Therapy Evaluation Form and Nurse Aide Instruction Sheet, as well as being properly placed on the Plan of Care sent to the physician.
2. The above form design will contain a checkbox to differentiate between continuous feed oxygen delivery and intermittent delivery.

3. The Medical Record Technicians, one of whom enters the data from the OASIS assessment form for entry to the Plan of Care, will be trained to look for and assure that all components are accurately transferred into the POC.
4. Training for therapists and RN Case Coordinators will take place to assure that they understand the absolute requirement to observe the patient's home environment for all sorts of supportive devices, DME, and supplies; such as: grab bars, toilet extensions, safety bars, wheelchairs, walkers, canes, TED hose, braces, oxygen apparatus, lift devices, glucometers, ramps, grabbers, etc.
5. Training for therapists and RN Case Coordinators will also stress the importance of identifying the diet and fluid emphasis prescribed by the patient's physician.
6. Training will also be held for LPN's and CNA's to watch for and report any DME, equipment, therapeutics, supplies, changes in diet, or medications which have not been reflected on the Plan of Care or the Aide Instruction Sheet. They will be instructed to report any such aberrations in writing to the RN Case Coordinator or Therapist as quickly as possible.

DESCRIPTION OF PROCESS IMPROVEMENT:

1. Through a combination of form redesign and education of staff and contractors evaluators will be responsible to be more attentive to recording all possible DME, supplies, or new medications and reporting them properly.
2. Training of service staff and contractors will emphasize the need to assure that the patient's current prescribed therapeutic diet and fluid emphasis be identified, recorded properly, and passed on to other caregivers by means of the Plan of Care and the Aide Instruction Sheet.
3. Medical Record Technicians will more closely monitor changes and additions to the patient's environment through reading and reviewing notes and documentation. They will also watch for diet changes and assure that these changes are properly noted. Medications which are mentioned in staff notes will be reported to the Case Coordinator to assure that the POC, the medication sheet in the agency record, and the medication sheet in the patient home all agree.

PROCEDURES TO IMPLEMENT PLANNED ACTION:

1. A training session will be held for RN's and Therapists, as well as a separate session for LPN's and Aides to assure that they understand the evaluation process and assure that all DME, supplies, and medications are properly recorded.
2. Medical Record Technicians will be reading Skilled Nurse, Therapist, and Aide Notes to observe if any new items are brought into the patient's environment; such as: DME, medical supplies, and new medications. They will report these new items, or omissions, to the appropriate professional for documentation by means of the POC or a verbal order form. The physician will be informed by way of modified orders to acknowledge the new device, supply, diet, or medication.

MONITORING AND TRACKING PROCEDURES:

1. Medical Record Technicians will be reading Skilled Nurse, Therapist, and Aide Notes to observe if any new items are brought into the patient's environment; such as: DME, medical supplies, and new medications. They will report these new items, or omissions, to the appropriate professional for documentation by means of the POC or a verbal order form. The physician will be informed by way of modified orders to acknowledge the new device, supply, diet, or medication.

2. The RN Supervisor and the Clinical Director will supervise the activities of the Medical Record Technicians and meet regularly with the RN Case Coordinators and Therapists to assure the proper application of agency policy.

COMPLETION DATE: 6/29/2012

PERSON(S) RESPONSIBLE TO SEE ACTION IS CARRIED OUT: Daniel Knight, RN, Clinical Director, Marie Kraus, RN Supervisor, and Kathy Anderson, LPN, Medical Record Technician.

G-176, 484.30(a) DUTIES OF THE REGISTERED NURSE
G-225, 484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE
N-098, 03.07024 SKILLED NURSING SERVICE – REGISTERED NURSE

CORRECTIVE ACTIONS TO BE TAKEN:

1. Training of RN Case Coordinators and Therapists, as well as separate sessions for LPN's and CNA's, will take place. An emphasis will be placed on the following: (a) providing reasonable assessment ranges for blood sugars, blood pressures, pulse rates, or other parameters set for evaluation. These ranges should be broader and reflect the latest professional practice for normal ranges in these indices. (b) An emphasis will also be placed on properly reporting assessed values which are outside of the above-mentioned ranges established by the case coordinator. (c) An emphasis will be placed on values which must be recorded to the physician. The RN Case Coordinator, with the assistance of the RN Supervisor, will determine those values which should be reported to the physician. In some cases, the physician will have already communicated those values he/she is interested in by means of an order.
2. The Medical Record Technicians will be reading Skilled Nursing Notes and Aide Notes and will report results which are out of scale and are not properly reported to the RN Supervisor or the Clinical Coordinator. They will be responsible to assure the report is made and recorded properly and determine if a report must be made to the physician.
3. As required by Medicare regulation, the agency produces an update for the physician to accompany any Recertification of the Plan of Care every 60 days. The Medical Record Technician will assure that a listing of out-of-range values are reported at that time. Fax reports may also be sent to the physician any time a RN Case Coordinator or the Therapist finds that a patient's values are out-of-range too often.

DESCRIPTION OF PROCESS IMPROVEMENT:

1. The training emphasis will improve vigilance on the part of service staff to changes in the patient's vital signs and blood values.
2. The continued review of records by the Medical Records Technicians will assure that aberrations in the normal vital signs and blood values will be captured and the proper individuals informed, including reports to the physician.

PROCEDURES TO IMPLEMENT PLANNED ACTION:

1. Training sessions will take place to emphasize proper practice with all classes of caregivers.
2. Tracking and monitoring of notes will assure that proper reporting will take place.

MONITORING AND TRACKING PROCEDURES:

1. As described above, the Medical Records Technicians will read and report improperly recorded or non-reported aberrations in vital signs and blood values and report them to their supervisor and the physician as needed.

2. The RN Supervisor and the Clinical Director will supervise the activities of the Medical Records Technicians.
3. The RN Supervisor and the Clinical Director will meet with all service staff on a regular basis, and with the RN Case Coordinators and Therapists regularly to review patients with them and identify problems and formulate solutions.

COMPLETION DATE: 6/29/2012

PERSON(S) RESPONSIBLE TO SEE ACTION IS CARRIED OUT: Daniel Knight, RN, Clinical Director, Marie Kraus, RN Supervisor, and Kathy Anderson, LPN, Medical Record Technician.

G-224, 484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE
G-225, 484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE
N-122, 03.07024 SKILLED NURSING SERVICE – TRAINING, ASSIGNMENT, INSTRUCTION OF HOME HEALTH AIDE

CORRECTIVE ACTIONS TO BE TAKEN:

1. The Aide Instruction Sheet will be modified to allow the RN more room to include better reporting parameters, DME and supplies in the home, and expectations, such as "Velma needs to soak when in the tub." Diet and fluid requirements will be emphasized so that the aides are properly aware of dietary needs for each patient. A place will also be included for more complete oxygen orders for each patient. In addition, detailed information will be provided by the RN Case Coordinators if the CNA is expected to assist the patient by reminding them to take medications.
2. Training will be conducted with the LPN's and CNA's to emphasize the importance of understanding the Aide Instruction Sheet, complying with each requirement set by the RN Case Coordinator, and understanding the importance of reporting any vital signs which are outside the parameters set in the POC and Aide Instruction Sheet.
3. Training will be conducted with the RN Case Coordinators to emphasize setting reasonable parameters for reporting, including specific instructions, and informing the aides of medications, diets, DME, and medical supplies in the patient's home.
4. The Medical Record Technician will read and report any aide notations which are not in compliance with the parameters and instructions. She will first report to the RN Case Coordinator and also report to the RN Supervisor.

DESCRIPTION OF PROCESS IMPROVEMENT:

1. The Aide Instruction Sheet will be more complete and allow more room for the RN Case Coordinator to outline the expectations on each aide during each visit.
2. The training described will inform the CNA's of the importance of the Aide Instruction Sheet and remind them of their responsibility to follow the instructions and document variations appropriately.

PROCEDURES TO IMPLEMENT PLANNED ACTION:

1. The Aide Instruction Sheet will be modified as described above.
2. Training sessions will carefully instruct all parties in the proper use of the Aide Instruction Sheet.
3. A tracking mechanism will assure that the procedures are followed appropriately. Variations will be reported to the RN Supervisor for her intervention.

MONITORING AND TRACKING PROCEDURES:

1. The Medical Records Technicians read all aide and skilled nurse notes and will monitor compliance with the instructions and report variations.

2. The RN Supervisor and the Clinical Director will supervise the activities of the Medical Record Technicians and will instruct the RN Case Coordinators in the preparation of the Aide Instruction Sheets.

COMPLETION DATE: 6/29/2012

PERSON(S) RESPONSIBLE TO SEE ACTION IS CARRIED OUT: Daniel Knight, RN, Clinical Director, Marie Kraus, RN Supervisor, and Kathy Anderson, LPN, Medical Record Technician.

G-336, 484.55(b)(3) COMPLETION OF COMPREHENSIVE ASSESSMENT

CORRECTIVE ACTIONS TO BE TAKEN:

1. The agency will develop procedures to have RN's perform a general evaluation on Therapy-Only patients whenever possible; these visits may or may not be reimbursable, but will be performed to assure that all elements of the comprehensive assessment will be completed.
2. Training will be conducted with the Therapists to explain and review the OASIS and the comprehensive assessment and their need to complete every portion of the comprehensive assessment form.
3. The Medical Record Technicians will review comprehensive assessments wherever more than one professional discipline is producing assessments (such as PT and OT). The Technician will review the assessments to assure a reasonable degree of agreement with respect to diagnoses, treatment regimens, etc. The Technician will report improper variations to the Clinical Director who will discuss the matter with the therapists.
4. Any Therapist completing a comprehensive assessment (OASIS) form will be required to complete all aspects of the assessment form including vital signs. The above-mentioned training session will contain information regarding this requirement.

DESCRIPTION OF PROCESS IMPROVEMENT:

1. Where ever possible Therapy-Only patients will receive an initial evaluation by an RN. If this is not possible, the Therapist evaluation will be carefully reviewed to assure it is complete.
2. Training will emphasize the process of completing a comprehensive assessment form for both RN's and Therapists.
3. Medical Record Technicians will observe this process and report variations to their supervisor.

PROCEDURES TO IMPLEMENT PLANNED ACTION:

1. A training session will be held to assure compliance with the above procedures.
2. The process will be tracked and monitored by Medical Record Technicians.

MONITORING AND TRACKING PROCEDURES:

1. The Medical Record Technicians will read comprehensive assessments and watch for incomplete portions or inconsistent evaluations and report to their supervisor.
2. The RN Supervisor and the Clinical Director will supervise the process and the Technicians to assure that the procedures are followed.

COMPLETION DATE: 6/29/2012

PERSON(S) RESPONSIBLE TO SEE ACTION IS CARRIED OUT: Daniel Knight, RN, Clinical Director, Marie Kraus, RN Supervisor, and Kathy Anderson, LPN, Medical Record Technician.

G-337, 484.55(c) DRUG REGIMEN REVIEW
N-173, 03.07030.07 PLAN OF CARE

CORRECTIVE ACTIONS TO BE TAKEN:

1. Initial Assessments of patients as they are admitted will include a comprehensive listing of medications taken by the patient, including prescription medication, PRN medication, inhalants, suppositories, over-the-counter (OTC) medications, etc. The RN will carefully note the prescription as written on the prescription bottles. She will also interview the patient or family member to assure that the patient is taking the medication appropriately. The Medication Sheet will be developed.
2. This information will be carefully transcribed onto the Plan of Care and a copy of the list will be maintained in the patient home in the agency binder. This will include all OTC medications. If the patient needs assistance with the medications, instructions for caregivers should be included.
3. The agency uses standard PDR software to input the medications taken by the patient and to produce a report which highlights possible interactions and contraindications. When the RN reviews the report she initials the report.
4. As each discipline visits the home they should make note of new or modified prescriptions, or added OTC medications, and make note of them in their discipline's notes. The discipline – CNA or Therapist – should inform the RN Case Coordinator or the RN Supervisor of the additional medication so a verbal order form may be forwarded to the physician. They may also make note in the Medication Record in the WVNI Binder in the patient home.
5. The Medical Record Technicians, as they read the notes or receive information from an RN or Therapist, will note any additional medications and make sure that they are recorded on the Medication Record in the patient's record.
6. When the RN reviews the patient's medical record she revises the Medication Record and/or initials it if no changes are noted. It is the responsibility of the RN Case Coordinator to assure that the POC and phone orders agree with the Medication Sheets in the patient record in this office and the copy in the patient's home in the agency binder.

DESCRIPTION OF PROCESS IMPROVEMENT:

1. The record in the agency and the record in the WVNI binder in the home should agree with each other, and with the Plan of Correction and Verbal Orders in the chart.
2. The Medication Record in the home should be accurate and will be the guide for the other disciplines in ascertaining if the patient is taking their medications properly.
3. The Medical Record Technicians will review the notes and the Medication Records and confirm their agreement and point out variations first to the RN Case Coordinator and second to the RN Supervisor.

PROCEDURES TO IMPLEMENT PLANNED ACTION:

1. Training will be given to the RN's, LPN's, and CNA's, as well as to the Therapists, to assure they understand the proper procedure and their continued responsibility to assure the accuracy of the Medication Record.
2. The Medical Record Technicians will monitor the process and note problems and seek resolution. They will take care to note logical inconsistencies; such as a patient who takes potassium supplements regularly but only takes diuretics sporadically.

MONITORING AND TRACKING PROCEDURES:

1. The Medical Record Technicians will read the notes, add new or changed medications to the Medication Record, and inform the RN's and their supervisor of the change.
2. The RN Supervisor and the Clinical Director will provide the training and supervise the Medical Record Technicians in their monitoring activities.

COMPLETION DATE: 6/29/2012

PERSON(S) RESPONSIBLE TO SEE ACTION IS CARRIED OUT: Daniel Knight, RN, Clinical Director, Marie Kraus, RN Supervisor, and Kathy Anderson, LPN, Medical Record Technician.

Sincerely,

Tami Miles-Banda MPH
Administrator

Daniel W. Knight, RN
Clinical Director

Dextral D. Miles, MBA
Vice-President of the Board of Directors