

COPY



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

May 24, 2011

Duke Vancampen, Administrator
Guardian Home Care
5700 East Franklin Road, Suite 250
Nampa, ID 83687

RE: Guardian Home Care, Provider #137100

Dear Mr. Vancampen:

This is to advise you of the findings of the complaint survey at Guardian Home Care, which was concluded on May 11, 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.

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

Duke Vancampen, Administrator
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June 6, 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
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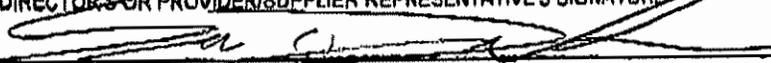
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/11/2011
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NAME OF PROVIDER OR SUPPLIER GUARDIAN HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 512 NORTH KINGS ROAD NAMPA, ID 83687
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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 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during a complaint investigation of your agency. The surveyors conducting the survey were:</p> <p>Teresa Hamblin RN, MS, HFS, Team Leader Aimee Hastriter RN, BS, HFS</p> <p>Acronyms used in this report include:</p> <p>ALF - Assisted Living Facility CNA - Certified Nursing Assistant LPN - Licensed Practical Nurse POC - Plan of Care RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care</p>	G 000	<p>G103</p> <p>05/12/2011 A meeting of the management staff of Guardian Home Care met to discuss tentative survey results and determine a plan of action. The plan determined the following:</p> <ol style="list-style-type: none"> 1. Review and revise appropriate policies. 2. Review and revise any appropriate processes 3. Educate staff to any changes and to Guardian's policy 4. Provide ongoing oversight to assure compliance <p>05/16/2011 Management team members met to review and propose potential revisions to policies to assure compliance with state and federal regulations.</p> <p>Policy #201 was reviewed and found to be in compliance with state and federal regulations. No changes made. See Attachments 1-2</p> <p>(cont)</p>	6/7/11
G 103	<p>484.10(a)(2) NOTICE OF RIGHTS</p> <p>The HHA must maintain documentation showing that it has complied with the requirements of this section.</p> <p>This STANDARD is not met as evidenced by: Based on medical record review, review of agency policies, and staff interview it was determined the agency failed to ensure the patient/guardian signed patient rights information upon admission. This impacted 1 of 4 patients (#2) whose records were reviewed and had the potential to result in provision of care without patient/guardian knowledge of patient rights. Findings include:</p> <p>1. The agency's "Admission Procedure Policy," revised 6/21/10, was reviewed. The policy indicated the patient and/or designated individual</p>	G 103		

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JUN - 8 2011
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 6-8-11
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A 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 reportable on days

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G 103	<p>Continued From page 1</p> <p>confirmed understanding of admission information by signing all applicable forms. The policy further indicated if the designated individual was not available for the start of care, verbal authorization was obtained and documented on a progress note. According to the policy, the forms were then sent to the designated individual for signature, along with a copy for reference purposes.</p> <p>Documentation of receipt of patient rights information was not obtained as follows:</p> <p>a. Patient #2 was a 93 year old female admitted to home health services on 3/09/11 for care of a wound on her left heel. She resided in an ALF. Her medical record contained a form from the ALF titled, "RESIDENT ADMISSION/EMERGENCY TRANSFER SHEET." This form contained emergency contact information for Patient #2 and indicated Patient #2's daughter, who lived locally, was her power of attorney.</p> <p>Patient #2's medical record contained the following forms which were to be signed by the patient/guardian as proof patient rights information had been provided prior to the start of care:</p> <p>- The "ADMISSION SERVICE AGREEMENT" contained sections for consent to care and services (including which disciplines would see the patient), authorization to release information, liability of payment and billing information, assignment of benefits, and acknowledgement of receipt of written information on the following: advanced directives, patients' rights and</p>	G 103	<p>06/06/2011</p> <p>Inservice completed by Jesse Zappia RN and Amy Mansfield RN, branch managers of the Nampa, Pocatello and Twin Falls sights. See Attachments 3-4</p> <p>Future Follow Up:</p> <ul style="list-style-type: none"> A random sampling review of files will be completed by the Corporate Compliance Officer to assure that Patient's Rights are being honored. The consent form inservice and who can legally sign the consent forms will be repeated on a regular basis to assure the staff is aware of federal and state requirements and Guardian's policy. 	

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G 103	<p>Continued From page 2</p> <p>responsibilities, statement of patient privacy rights, basic home safety, emergency planning, and infection control. A line for "Patient Signature or Authorized Representative" was signed. A line designated "Relationship (if authorized representative)" contained the letters "CNA." The form was dated 3/09/11.</p> <p>- A form titled "CONSENT FOR SERVICES AGREEMENT" contained information related to insurance billing, consent for treatment, authorization to release information, and an agreement to notify the agency within 24 hours with any change of insurance information. A line for "Patient Signature (or Authorized Representative)" was signed. A line designated "Relationship" contained the letters "CNA." The form was dated 3/09/11.</p> <p>- A form titled "PATIENT LIABILITY NOTIFICATION" contained billing information. The form contained a line at the bottom for "Patient/Guarantor Signature." The form was signed by the same individual as the forms above. Below this line it read, "By signing, I acknowledge receipt of this information. I also understand that I am financially responsible for all charges whether covered/paid by insurance or not." The form was dated 3/09/11.</p> <p>The Corporate Compliance Officer was interviewed on 5/09/11 at 4:00 PM. She stated if a patient was unable to sign the admission paperwork, the patient's representative was asked to be at the admission assessment to sign for them. If this was not possible, the information was to be relayed verbally to the representative and the paperwork forwarded to the</p>	G 103			

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G 103	Continued From page 3 representative for signatures. She stated it was not appropriate for a CNA to sign the admission consent and patient rights paperwork. In an interview on 5/11/11 at 2:15 PM, the Corporate Compliance Officer verified the CNA who signed the paperwork was a staff member at the ALF where Patient #2 resided. She stated the CNA was not the patient's legal representative.	G 103		
G 107	484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint. This STANDARD is not met as evidenced by: Based on agency and ALF staff interview and review of patient records, agency policies, and incident reports, it was determined the agency failed to ensure a complaint/incident involving patient care was thoroughly investigated and the resolution of the complaint was documented for 1 of 2 patients (#1) whose complaints/incidents were documented during 2011 and filed in the Incident reporting log. Failure to fully investigate the incident resulted in a missed opportunity for performance improvement. It also resulted in a	G 107	G107 05/12/2011 A meeting of the management staff of Guardian Home Care met to discuss tentative survey results and determine a plan of action. The plan determined the following: 1. Review and revise appropriate policies. 2. Review and revise any appropriate processes 3. Educate staff to any changes and to Guardian's policy 4. Provide ongoing oversight to assure compliance (cont)	6/7/11

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G 107	<p>Continued From page 4</p> <p>failure to determine if a patient required follow-up to an incident. Findings include:</p> <p>Patient #1 was an 87 year old female who lived in an ALF. She was admitted to the home health agency on 2/17/11 for care primarily related to a foot ulcer. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 2/17/11 to 4/17/11, described Patient #1 as forgetful, depressed, and disoriented with impaired decision-making.</p> <p>An "Incident Report," dated 4/05/11, completed by the home health agency's Clinical Branch Director, documented a complaint received from ALF staff. The "Incident Report" indicated a tourniquet had been left on Patient #1's arm after a blood draw performed by home health agency staff on 4/05/11. In response to the complaint, the Clinical Branch Director documented contacting the LPN who drew Patient #1's blood on 4/05/11. He inquired about the incident and asked the LPN to complete an incident report. The Clinical Branch Director further documented the LPN reported taking off the tourniquet and placing it Patient #1's lap. It also stated the LPN had tried to reach ALF staff for follow-up but was unable to do so. The incident report documented to the author's knowledge no injuries were sustained related to the LPN's visit.</p> <p>An "Incident Report," signed by the LPN, was completed 4/06/11 for the event that occurred on 4/05/11. It described the LPN having drawn Patient #1's blood while Patient #1 was sitting in her wheelchair. After withdrawing blood into the syringe, the LPN picked up a piece of gauze, released the tourniquet and dropped it in Patient</p>	G 107	<p>05/16/2011 Management team members met to review and propose potential revisions to policies to assure compliance with state and federal regulations.</p> <p>Policies 215 and 236 were reviewed and revised to be in compliance with state and federal regulations. See Attachments 5-6</p> <p>06/06/2011 Inservice completed by Jesse Zappia RN and Amy Mansfield RN, branch managers of the Nampa, Pocatello and Twin Falls sights. See Attachments 7</p> <p>Future Follow Up:</p> <ul style="list-style-type: none"> A random sampling review of files will be completed by the Corporate Compliance Officer to assure that Patient's Rights are being honored. The branch manager will review any client issues <p style="text-align: right;"><i>(cont)</i></p>	
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G 107	<p>Continued From page 5</p> <p>#1's lap as both of his hands were busy. Afterward he realized he had not taken the tourniquet or gauze back from Patient #1. There was no documentation of follow-up to the complaint or incident. The report documented no injuries were sustained. There was no documentation to indicate how this conclusion was made.</p> <p>The LPN who performed the blood draw was interviewed by telephone on 5/11/11 at 2:45 PM. He stated that upon initial reflection he wondered if he left the tourniquet on Patient #1. However, he stated, after reviewing steps in his mind, he was sure he had released the tourniquet, but forgot to take it with him.</p> <p>During a visit to the ALF on 5/09/11 the "Resident Service Notes," dated 4/05/11 (untimed), for Patient #1 were reviewed. The notes, signed by an ALF LPN, documented Patient #1 wheeled herself in a wheelchair up to the ALF administrator and handed the administrator a tourniquet and gauze. It also documented the home health agency nursing staff had been in to see Patient #1 about 30 minutes prior to draw blood for lab work. The note further documented the ALF LPN notified the ALF owner of the incident and left a message with Patient #1's Home Health Case Manager regarding the tourniquet being left on Patient #1. The ALF LPN also documented she checked Patient #1's arm and did not note any injury.</p> <p>The ALF LPN who wrote the above referenced note was interviewed on 5/09/11 at 2:25 PM. She stated she did not see the tourniquet on Patient #1 but received a report from the administrator</p>	G 107	<p>and determine if the correct form is completed and that the follow up is completed according to Guardian policy.</p> <ul style="list-style-type: none"> Inservicing regarding client concerns, grievances, and incidents will be repeated on a regular basis with all staff to assure compliance with this regulation. 	

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G 107	<p>Continued From page 6</p> <p>who had seen it. She referred this surveyor to the administrator for more information.</p> <p>Two ALF Administrators were interviewed on 5/09/11 at 2:30 PM. They both stated that Patient #1 wheeled herself to them while they were in a staff meeting. They said a tourniquet was on Patient #1's arm and Patient #1 reported her arm hurt. Patient #1 then reached over and released the tourniquet and handed it to one of the administrators. One administrator stated she rubbed Patient #1's arm to make it feel better and noticed a ring around Patient #1's arm where the tourniquet had been.</p> <p>The agency's "Patient Incident Policy," dated 6/02/10, stated that in the event of an incident that was either reported or observed in the patient's place of residence, certain actions would be taken by staff. Licensed personnel would assess the patient after the incident and notify the physician of the incident whether the incident resulted in injury or non-injury. These steps were not taken. It further stated that the Home Health manager would investigate the incident, provide follow-up as needed, and document the follow up on the Incident Report or an addendum. The only documented follow-up, taken by the agency, was asking the LPN if the event actually occurred and asking the LPN to complete an incident report. There was no documentation of interviewing witnesses to the event or any corrective instruction, if appropriate, to the LPN who may have left the tourniquet on Patient #1. During an interview on 5/09/11 at 9:35 AM, the Clinical Branch Director confirmed no additional investigation or staff instruction was done.</p>	G 107		
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G 107	Continued From page 7 Patient #1's Home Health Case Manager was interviewed on 5/09/11 at 9:35 AM. She stated the ALF LPN left a message on her phone reporting a tourniquet was left on Patient #1 and that the ALF LPN had checked Patient #1's arm and did not note any injury. She stated she did not document the telephone call. She also indicated she did not follow-up with Patient #1.	G 107		
G 141	484.14(e) PERSONNEL POLICIES Personnel practices and patient care are supported by appropriate, written personnel policies. Personnel records include qualifications and licensure that are kept current. This STANDARD is not met as evidenced by: Based on staff interview and review of personnel records and the job description for LPNs, it was determined the agency failed to ensure personnel records included documentation of demonstrated competency of LPNs to perform venipuncture for 3 of 3 LPNs (A, B, and C) whose personnel files were reviewed. This had the potential to indicate LPN staff was not qualified to perform venipuncture for blood draws. Findings include: An LPN job description, dated 3/03/10, stated an LPN could perform routine venipuncture (phlebotomy) if the personnel record contained written documentation of competency. An RN	G 141	G141 05/12/2011 A meeting of the management staff of Guardian Home Care met to discuss tentative survey results and determine a plan of action. The plan determined the following: 1. Review and revise appropriate policies. 2. Review and revise any appropriate processes 3. Educate staff to any changes and to Guardian's policy 4. Provide ongoing oversight to assure compliance <i>(cont)</i>	6/7/11

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G 141	<p>Continued From page 8</p> <p>was to evaluate competency even if the LPN had completed a certification course.</p> <p>Three LPN personnel files were reviewed. At the time of the initial surveyor request, on 5/09/11, agency staff was not able to provide written documentation in personnel files of LPN competency for venipuncture for collecting blood specimens. Personnel records for LPN A and LPN B contained a "NURSING SKILLS CHECKLIST" that documented the LPNs felt competent performing venipuncture for blood work. There was no documentation an RN had evaluated each LPN's performance of venipuncture skills as required by agency policy. The personnel record for LPN C did not contain a "NURSING SKILLS CHECKLIST" or documentation of demonstrated competency by an RN. It contained a certificate of completion of a venipuncture course, dated 1/21/11.</p> <p>On 5/10/11, the Corporate Compliance Officer provided a copy of LPN C's "NURSING SKILLS CHECKLIST." She stated it had not been in the personnel file because the LPN had it in his possession.</p> <p>During a telephone interview on 5/11/11 at 2:30 PM, the Corporate Compliance Officer confirmed all three LPNs had been performing venipuncture, and therefore the requirement to have demonstrated competency was relevant to all three LPNs. She acknowledged the personnel records did not include documentation of demonstrated competency.</p> <p>Personnel records were not kept current related to LPN competence in performing venipuncture</p>	G 141	<p>05/16/2011 Management team members met to review and propose potential revisions to policies to assure compliance with state and federal regulations.</p> <p>Policies 1520 and 1404 were reviewed and revised to be in compliance with state and federal regulations. See Attachments 8-10</p> <p>06/06/2011 Inservice completed by Jesse Zappia RN and Amy Mansfield RN, branch managers of the Nampa, Pocatello and Twin Falls sights. See Attachments 11</p> <p>Future Follow Up:</p> <ul style="list-style-type: none"> A random sampling review of employee files will be completed by the Corporate Compliance Officer to assure that employee files are completed per Guardian's policy The branch manager (cont) 	

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G 141 G 159	<p>Continued From page 9 for blood draws.</p> <p>484.18(a) PLAN OF CARE</p> <p>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.</p> <p>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 reporting parameters for blood sugars for 1 of 1 patient (#4) who had diabetes whose POC was reviewed. This resulted in blood sugars that were out of normal range not being reported to the physician. This had the potential to interfere with optimum management of the patient's diabetes. Findings include:</p> <p>Patient #4 was a 57 year old diabetic male who was admitted to the agency on 4/09/11 for care primarily related to wound care. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 4/09/11 to 6/07/11, included physician orders for SN to "review blood glucose levels each visit with patient/ ALF staff" and to "assess blood glucoses." The POC did not include specific parameters for when to report blood glucose results to the physician. The POC did include a goal for Patient #4's blood glucoses to be greater than 80 mg/dl and less than 250</p>	G 141 G 159	<p>will assure that all Licensed Practical Nurse hires, from this date forward, will have skills evaluated and documented prior to independently performing those skills with patients</p> <ul style="list-style-type: none"> The Human Resources, who maintain the personnel files, will assure that the skills checklist is completed and in the employees file. The Human Resources employee will follow up with the branch manager for any paper work missing. If the branch manager does not respond in a timely manner to the Human Resources employee, the Chief Operations Officer will be noted for additional follow up. <p>G 159 05/12/2011 A meeting of the management staff of Guardian Home Care met to discuss tentative survey results and determine a plan of action. The plan determined the following: (cont)</p> 	6/7/11
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER GUARDIAN HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 512 NORTH KINGS ROAD NAMPA, ID 83687
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G 159	<p>Continued From page 10 mg/dl over the next 60 days.</p> <p>The following blood sugars and blood sugar ranges were documented in Patient #4's record:</p> <p>RN SOC visit note, dated 4/09/11 at 1:45 PM documented a blood sugar of 275 with a normal range of 224 to 396.</p> <p>LPN visit note, dated 4/11/11 at 3:12 PM documented blood sugars in the "100s."</p> <p>LPN visit note, dated 4/18/11 at 10:05 AM documented blood sugars that ranged from 200 to 300.</p> <p>LPN visit note, dated 4/20/11 1:39 PM, documented a blood sugar of 338.</p> <p>LPN visit note, dated 4/25/11 at 5:18 PM, did not document blood sugar results.</p> <p>LPN visit note, dated 4/27/11 at 2:51 PM, documented a blood sugar of 337.</p> <p>RN visit note, dated 5/02/11 at 5:25 PM, did not document blood sugar results.</p> <p>LPN visit note, dated 5/09/11 at 3:05 PM, documented a blood sugar of 339.</p> <p>The Case Manager for Patient #4 was interviewed on 5/10/11 at 9:00 AM. She stated that she had known Patient #4 for a long time as he had intermittently been on service with the home health agency. She stated Patient #4's circumstances were better than they had been in the past. She confirmed the goal for Patient #4's</p>	G 159	<ol style="list-style-type: none"> 1. Review and revise appropriate policies. 2. Review and revise any appropriate processes 3. Educate staff to any changes and to Guardian's policy 4. Provide ongoing oversight to assure compliance <p>05/16/2011 Management team members met to review and propose potential revisions to policies to assure compliance with state and federal regulations.</p> <p>Policies 905 and 907 were reviewed and revised to be in compliance with state and federal regulations. See Attachments 12-13</p> <p>06/06/2011 Inservice completed by Jesse Zappia RN and Amy Mansfield RN, branch managers of the Nampa, Pocatello and Twin Falls sights. See Attachments 14</p> <p style="text-align: right;"><i>(cont)</i></p>	
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G 159	<p>Continued From page 11</p> <p>blood sugars to fall within the goal ranges of 80 to 250 mg/dl. She stated she did not feel it was necessary to report his blood sugars because the ALF staff was available to monitor the blood sugars and Patient #4 was doing so well compared to the past. She stated, although the goal was 80 to 250 mg/dl, she did not feel it necessary to contact the physician unless the blood sugar was quite a bit higher because he often ran high normally.</p> <p>During an interview on 5/10/11 at 9:25 AM, the Clinical Branch Director, stated nursing staff was expected to write reporting parameters in the Intervention section of the Plan of Care. If there were no reporting parameters, nurses were expected to report blood glucose levels that fell outside of the ranges listed in the goals. If goals were not listed, nursing staff were expected to use standard lab values for reporting.</p> <p>During a second interview on 5/01/11 at 10:15 AM, the Clinical Branch Director referred to the Lippincott Manual as an example of an acceptable resource to determine normal ranges for blood glucose levels, which he stated were in the "60 to 120 range." He further stated that nursing staff was aware to report blood glucose ranges that fell outside of the goal ranges, unless more specific parameters were included on the POC.</p>	G 159	<p>Future Follow Up:</p> <ul style="list-style-type: none"> • A random sampling review of files will be completed by the Corporate Compliance Officer to assure that measurable, patient specific items, not within the care plan range designated, is reported to the physician. • The Utilization Review Nurses will review the plans of care prior to sending to the physician, to determine if further clarification of ranges are needed. • The Plan of Care contents inservice will be repeated on a regular basis to assure the staff is aware of federal and state requirements and Guardian's policies. 	
G 164	<p>The POC did not include reporting parameters for blood sugars.</p> <p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE</p> <p>Agency professional staff promptly alert the</p>	G 164	<p>G 164 05/12/2011 A meeting of the management staff of Guardian Home Care met to discuss (cont)</p>	6/7/11

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G 164	<p>Continued From page 12</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 ensure nursing staff reported elevated blood sugars for 1 of 1 patient who had diabetes (#4) whose record was reviewed. This had the potential to interfere with the physician's management of the patient's diabetes. Findings include:</p> <p>Patient #4 was a 57 year old diabetic male who was admitted to the agency on 4/09/11 for care primarily related to wound care. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 4/09/11 to 6/07/11, included orders for SN to "review blood glucose levels each visit with patient/ ALF staff" and to "assess blood glucoses." The POC included a goal for Patient #4's blood glucoses to be greater than 80 and less than 250 over the next 60 days. The POC did not include specific reporting parameters.</p> <p>During an interview on 5/10/11 at 9:25 AM, the Clinical Branch Director stated the agency did not have any formal blood sugar reporting policy. He stated it was agency expectation that nursing staff write reporting parameters in the Intervention section of the POC. If the POC did not include specific reporting parameters, nurses were expected to report based on the goals listed on the POC. If goals were not listed, nursing staff were expected to report blood sugar ranges that fell outside of standard lab values.</p>	G 164	<p>tentative survey results and determine a plan of action. The plan determined the following:</p> <ol style="list-style-type: none"> 1. Review and revise appropriate policies. 2. Review and revise any appropriate processes 3. Educate staff to any changes and to Guardian's policy 4. Provide ongoing oversight to assure compliance <p>05/16/2011 Management team members met to review and propose potential revisions to policies to assure compliance with state and federal regulations.</p> <p>Policies 905 and 907 were reviewed and revised to be in compliance with state and federal regulations. See Attachments 15-16</p> <p>06/06/2011 Inservice completed by Jesse Zappia RN and Amy Mansfield RN, branch</p> <p style="text-align: right;">(cont)</p>	
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G 164	<p>Continued From page 13</p> <p>During a second interview on 5/01/11 at 10:15 AM, the Clinical Branch Director referred to resources, such as the Lippincott Manual, to identify normal ranges for blood sugars which he stated were about 60-120. He further stated that nursing staff knew to report blood sugars outside of goal ranges if no other specific reporting parameters were listed on the POC. If reporting parameters were different than the goal ranges, they should be listed on the POC and reported to the physician accordingly.</p> <p>The following blood sugars and blood sugar ranges were documented in Patient #4's record:</p> <p>RN SOC visit note, dated 4/09/11 at 1:45 PM documented a blood sugar of 275 with a normal range of 224 to 396.</p> <p>LPN visit note, dated 4/11/11 at 3:12 PM documented blood sugars in the "100s."</p> <p>LPN visit note, dated 4/18/11 at 10:05 AM documented blood sugars that ranged from 200 to 300.</p> <p>LPN visit note, dated 4/20/11 1:39 PM, documented a blood sugar of 338.</p> <p>LPN visit note, dated 4/25/11 at 5:18 PM, did not document blood sugar results.</p> <p>LPN visit note, dated 4/27/11 at 2:51 PM, documented a blood sugar of 337.</p> <p>RN visit note, dated 5/02/11 at 5:25 PM, did not document blood sugar results.</p>	G 164	<p>managers of the Nampa, Pocatello and Twin Falls sights. See Attachments 17</p> <p>Future Follow Up:</p> <ul style="list-style-type: none"> A random sampling review of files will be completed by the Corporate Compliance Officer to assure that measurable, patient specific items, not within the care plan range designated, is reported to the physician. The Utilization Review Nurses will review the plans of care prior to sending to the physician, to determine if further clarification of ranges are needed. The Plan of Care contents inservice will be repeated on a regular basis to assure the staff is aware of federal and state requirements and Guardian's policies. 	
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G 164	<p>Continued From page 14</p> <p>LPN visit note, dated 5/09/11 at 3:05 PM, documented a blood sugar of 339.</p> <p>There was no documentation nursing staff reported blood sugars that fell outside of goal ranges of 80 to 250 mg/dl.</p> <p>The Case Manager was interviewed on 5/10/11 at 9:00 AM. She stated that she had known Patient #4 for a long time as he had intermittently been on service with the home health agency. She stated Patient #4s circumstances were better than they had been in the past. She confirmed the goal for Patient #4's blood sugars to fall within the goal ranges of 80-250. She stated she did not feel it was necessary to report his blood sugars because the ALF staff was available to monitor the blood sugars and Patient #4 was doing so well compared to the past.</p> <p>Nursing staff did not report blood sugar results that fell outside of goal ranges and normal values.</p>	G 164		
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Bureau of Facility Standards

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during a complaint investigation of your agency. The surveyors conducting the survey were: Teresa Hamblin RN, MS, HFS, Team Leader Aimee Hastriter RN, BS, HFS	N 000	N016 05/12/2011 A meeting of the management staff of Guardian Home Care met to discuss tentative survey results and determine a plan of action. The plan determined the following: 1. Review and revise appropriate policies. 2. Review and revise any appropriate processes 3. Educate staff to any changes and to Guardian's policy 4. Provide ongoing oversight to assure compliance	6/7/11
N 016	03.07020. ADMIN. GOV. BODY N016 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: b. A patient has a right to be informed of his rights and has a right to be notified in writing of his rights and obligations before treatment is begun. HHAs must provide each patient and family with a written copy of the bill of rights. A signed, dated copy of the patient's bill of rights will be included in the patient's medical record. This Rule is not met as evidenced by: Refer to G 103.	N 016	Cont. on following added pages.	RECEIVED JUN - 8 2011 FACILITY STANDARDS
N 026	03.07020. ADMIN. GOV. BODY N026 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.viii. The HHA must investigate complaints made by a patient or the patient's family or guardian regarding	N 026	N026 05/12/2011 A meeting of the management staff of Guardian Home Care met to discuss tentative survey results and determine a plan of action. The plan determined the following: Cont. on following added pages	6/7/11

Bureau of Facility Standards

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

TITLE

Admin.

(X6) DATE

6-8-11

Bureau of Facility Standards

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N 026	Continued From page 1 treatment or care that is or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA and must document both the existence of the complaint and the resolution of the complaint. This Rule is not met as evidenced by: Refer to G 107.	N 026		
N 051	03.07021. ADMINISTRATOR N051 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: e. Personnel records of staff working directly with patients shall include: qualifications, licensure or certification when indicated, orientation to home health, the agency and its policies; performance evaluation, and documentation of attendance or participation in staff development, in-service, or continuing education; documentation of a current CPR certificate; and other safety measures mandated by state/federal rules or regulations. This Rule is not met as evidenced by: Refer to G 141.	N 051	N051 05/12/2011 A meeting of the management staff of Guardian Home Care met to discuss tentative survey results and determine a plan of action. The plan determined the following: 1. Review and revise appropriate policies. 2. Review and revise any appropriate processes 3. Educate staff to any changes and to Guardian's policy 4. Provide ongoing oversight to assure compliance <i>cont. on following added pages</i>	6/7/11
N 172	03.07030.06.PLAN OF CARE N172 06. Changes to Plan. Agency professional staff promptly alert the	N 172	N 172 05/12/2011 A meeting of the management staff of Guardian Home Care met to discuss (cont)	6/7/11

Bureau of Facility Standards

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N 172	Continued From page 2 physician to any changes that suggest a need to alter the plan of care. This Rule is not met as evidenced by: Refer to G 164.	N 172	<p>tentative survey results and determine a plan of action. The plan determined the following:</p> <ol style="list-style-type: none"> 1. Review and revise appropriate policies. 2. Review and revise any appropriate processes 3. Educate staff to any changes and to Guardian's policy 4. Provide ongoing oversight to assure compliance <p>05/16/2011 Management team members met to review and propose potential revisions to policies to assure compliance with state and federal regulations.</p> <p>Policies 905 and 907 were reviewed and revised to be in compliance with state and federal regulations. See Attachments 29-30</p> <p><i>Cont on following page</i></p>	

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HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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May 24, 2011

Duke Vancampen, Administrator
Guardian Home Care
5700 East Franklin Road, Suite 250
Nampa, ID 83687

Provider #137100

Dear Mr. Vancampen:

On **May 11, 2011**, a complaint survey was conducted at Guardian Home Care. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005007

Allegation #1: Agency staff left a tourniquet on a patient's arm after doing a blood draw.

Findings #1: An unannounced visit was made to the home health agency May 9 through May 11, 2011. During the complaint investigation, surveyors reviewed agency policies, job descriptions, personnel files, incident reports, complaints, 4 patient records, and observed patient care during 2 home visits. They also interviewed agency staff as well as staff from an Assisted Living Facility (ALF).

One patient record reviewed described an 87 year old female who lived in an ALF and was admitted to the home health agency on 2/17/11 for care primarily related to a foot ulcer. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 2/17/11 to 4/17/11, described the patient as forgetful, depressed, and disoriented with impaired decision-making.

An "Incident Report," dated 4/05/11, completed by the home health agency's Clinical Branch Director, documented a complaint received from ALF staff on behalf of the patient. A tourniquet had been left on the patient's arm after a blood draw performed by home health agency staff on

Duke Vancampen, Administrator
May 24, 2011
Page 2 of 3

4/05/11. In response to the complaint, the Clinical Branch Director documented contacting the Licensed Practical Nurse (LPN) who drew the patient's blood on 4/05/11. He inquired about the incident and asked the LPN to complete an incident report.

An "Incident Report," signed by the LPN, was completed 4/06/11 for the event that occurred on 4/05/11. It described the LPN having drawn the patient's blood while she was sitting in her wheelchair. After withdrawing blood into the syringe, the LPN picked up a piece of gauze, released the tourniquet and dropped it in the patient's lap as both of his hands were busy. Afterward he realized he had not taken the tourniquet or gauze back from the patient.

The LPN who performed the blood draw was interviewed by telephone on 5/11/11 at 2:45 PM. He stated that upon initial reflection he wondered if he left the tourniquet on the patient. However, he stated, after reviewing steps in his mind, he was sure he had released the tourniquet, but forgot to take it with him.

During a visit to the ALF on 5/09/11, surveyors reviewed the "Resident Service Notes," dated 4/05/11, for the patient. The notes, signed by an ALF LPN, documented the patient had wheeled herself in a wheelchair up to the administrator and handed the administrator a tourniquet and gauze. It also documented the home health agency nursing staff had been in to see the patient 30 minutes prior to draw blood for lab work. The note further documented the LPN notified the ALF owner of the incident and left a message with the patient's Case Manager regarding the tourniquet being left on the patient. The LPN also documented she checked the patient's arm and did not note any injury.

The ALF LPN who wrote the above referenced note was interviewed on 5/09/11 at 2:25 PM. She stated she did not see the tourniquet on the patient but had received a report from the administrator who had seen it. She referred this surveyor to the administrator for more information.

Two ALF administrators were interviewed on 5/09/11 at 2:30 PM. They both stated that the patient wheeled herself to them (on 4/05/11) while they were in a staff meeting. They said a tourniquet was on her arm and she reported her arm hurt. The patient then reached over and released the tourniquet and handed it to one of the administrators. One administrator stated she rubbed the patient's arm to make it feel better and noticed a ring around the patient's arm where the tourniquet had been.

The agency was cited at CFR 484.10(b)(5) for failure to ensure a complaint/incident involving patient care was thoroughly investigated and the resolution of the complaint was documented.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Duke Vancampen, Administrator

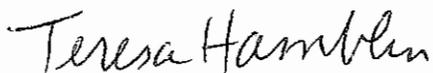
May 24, 2011

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Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srm