

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

June 27, 2011

Mary De Tienne, Administrator  
Panhandle Health District  
8500 N Atlas Road  
Hayden, ID 83835

RE: Panhandle Health District, Provider #137002

Dear Ms. De Tienne:

This is to advise you of the findings of the Medicare/Licensure survey at Panhandle Health District, which was concluded on June 17, 2011.

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

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

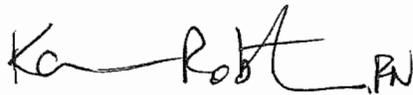
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date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

Mary De Tienne, Administrator  
June 27, 2011  
Page 2 of 2

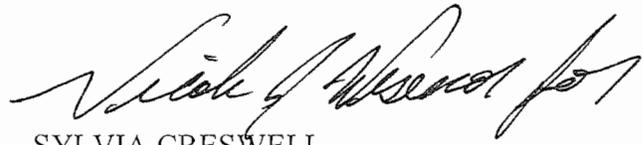
After you have completed your Plan of Correction, return the original to this office by **July 7, 2011**, and keep a copy for your records.

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,

Handwritten signature of Karen Robertson in black ink, including the initials "RN" at the end.

KAREN ROBERTSON  
Health Facility Surveyor  
Non-Long Term Care

Handwritten signature of Sylvia Creswell in black ink.

SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

KR/srm  
Enclosures

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

PRINTED: 06/24/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/17/2011
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NAME OF PROVIDER OR SUPPLIER  PANHANDLE HEALTH DISTRICT	STREET ADDRESS, CITY, STATE, ZIP CODE 8500 N ATLAS ROAD HAYDEN, ID 83835
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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
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G 000	INITIAL COMMENTS  The following deficiencies were cited during the recertification survey of your agency. The surveyors conducting the survey were:  Karen Robertson, RN, BS, HFS, Team Leader Susan Costa RN, HFS  Acronyms used in this report include:  CDC - Centers for Disease Control DME - Durable Medical Equipment OT - Occupational Therapy POC - Plan of Care PT - Physical Therapy RN - Registered Nurse SOC - Start of Care SN - Skilled Nurse ST - Speech Therapy	G 000		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES  The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the documentation of coordination of care between individuals providing patient care for 3 of 8 patients (#1, #9 and #12) with more than one discipline whose records were reviewed. This had the potential to interfere with the clarity of the course of care. Findings include:	G 144	Please refer to attached POC for Tags 144, 159, 160, and 337. Linda Karlgaard, Nurse Manager Karen Robertson, RN, BS, HFS 7/8/11	

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JUL - 7 2011  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mary S. ... St., RN Home Health Admin.</i>	TITLE	(X6) DATE 7/5/11
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 144	<p>Continued From page 1</p> <p>In an interview on 6/16/11 at 8:30 AM, the Nurse Manager stated after a therapist, such as OT or PT, completed their SOC evaluation, they always called and spoke with the Nurse Manager. She stated coordination was occurring between disciplines, but it was not always documented.</p> <p>1. Patient #12 was a 48 year old female admitted to the agency on 5/16/11 for care primarily related to rehabilitation.</p> <p>All disciplines' visit note forms, including evaluation/SOC forms, for the agency, included a box titled, "Care Coordination," or space to document coordination. The following visit notes did not include documentation of coordination of care:</p> <p>OT: 5/17/11 (SOC evaluation) and 5/18/11. PT: 5/24/11, 5/27/11, and 5/31/11. RN: 5/16/11 (SOC assessment).</p> <p>In an interview on 6/16/11 at 2:15 PM, the Nurse Manager confirmed she did not see documentation of coordination of care between disciplines for the above dates and disciplines.</p> <p>Coordination of care between disciplines was not documented.</p> <p>2. Patient #9 was a 3 year old female admitted to the agency on 5/25/11 for care primarily related to epilepsy.</p> <p>All disciplines' visit note forms, including evaluation/SOC forms, for the agency, included a box titled, "Care Coordination," or space to</p>	G 144		06/17/11

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G 144	<p>Continued From page 2</p> <p>document coordination. The following visit notes did not include documentation of coordination of care:</p> <p>RN: 5/25/11 (SOC assessment) PT: 5/26/11 (SOC evaluation), 6/02/11, and 6/09/11 OT: 6/08/11</p> <p>In an interview on 6/16/11 at 11:00 AM, the Nurse Manager confirmed she did not see documentation of coordination of care between disciplines for the above dates and disciplines.</p> <p>Coordination of care between disciplines was not documented.</p> <p>3. Patient #1 was a 13 year old male with a SOC of 1/08/09 for nursing care and therapy related to cerebral palsy and frequent episodes of pneumonia.</p> <p>"NURSING INTERVENTION" and "PT INTERVENTION" notes were reviewed during the certification period of 4/26/11 to 6/24/11 for documentation of coordination of care between the disciplines. There were 7 nursing visits and 14 PT visits, none of the notes documented care coordination.</p> <p>In an interview on 6/16/11 at 9:20 AM, the RN who provided care for Patient #1 reviewed the record and confirmed the lack of documentation of coordination of care. The RN stated she communicated frequently with the therapist who worked with Patient #1, but had not documented those activities. The RN stated discussion of Patient #1 was not included in the agency care</p>	G 144			

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G 144	Continued From page 3 conferences, as he was a long term pediatric patient.  In an interview on 6/15/11 at 8:20 AM, the Physical Therapist who provided care for Patient #1 reviewed the record and confirmed she had not documented communication with the RN. The Physical Therapist stated she frequently saw Patient #1 and her visits would overlap with the RN, at that time they would discuss his current status and their plans.  Coordination of care activities were not documented.	G 144		
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, staff interview, home visit, and patient interview, it was determined the agency failed to ensure plans of care covered all pertinent information for 4 of 16 patients (#1, #4, #5, and #8) whose records were reviewed. This had the potential to negatively impact quality, coordination, and completeness of patient care. Findings include:	G 159		

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G 159	<p>Continued From page 4</p> <p>1. Patient #5 was a 55 year old female who was admitted to the agency for wound care on 1/26/11. The "Recertification or Other Follow-Up," completed by an RN on 5/23/11 at 10:00 AM, stated Patient #5 had "Bipolar disorder." The recertification also stated Patient #5 was deaf in right and left ears. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 5/26/11 to 7/24/11, included orders for Paxil, Ativan, and Lamictal. It did not include a diagnosis of bipolar disorder or deafness.</p> <p>During a home visit on 6/15/11 at 9:00 AM, Patient #5 described her difficulties with depression, and stated she had a difficult time finding medication that would help her depression. Patient #5 stated she had lost her hearing in her left ear as a child, and she did not have hearing loss in her right ear. During the home visit, the RN provided wound care and Patient #5 was assisted into a foot brace. Patient #5 was instructed by the RN to wear the brace during the day.</p> <p>The Nurse Manager was interviewed on 6/16/11 at 5:00 PM. She reviewed Patient #5's record and confirmed that the diagnosis of bipolar disorder as well as deafness in the left ear should have been included in the POC. She agreed the diagnosis was pertinent and belonged in the POC. She also stated the brace for Patient #5's foot should have been included in the POC.</p> <p>The POC did not include pertinent diagnoses and DME.</p> <p>2. Patient #1 was a 13 year old male who was</p>	G 159			

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G 159	<p>Continued From page 5</p> <p>admitted to the agency on 1/08/09 to receive skilled nursing and physical therapy related to cerebral palsy and frequent respiratory infections. A "PEDIATRIC ASSESSMENT," dated 6/13/11 at 10:17 AM, stated Patient #1 wore a percussion vest twice daily. A PT evaluation for a resumption of care, dated 6/14/11 at 9:00 AM, stated equipment including a wheel chair, hospital bed, reclining shower bench and braces for each extremity were in place. None of these items were included in the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 4/26/11 to 6/24/11.</p> <p>During a home visit on 6/14/11 beginning at 9:00 AM, the mother of Patient #1 stated the percussion vest was used to help mobilize secretions, as her son was unable to cough.</p> <p>The Physical Therapist who provided care for Patient #1 was interviewed on 6/16/11 at 8:20 AM. She confirmed the DME was not included in the POC, although Patient #1 had the equipment prior to the recertification which was on 6/13/11. She stated there was no policy that described what items were to be included in the POC.</p> <p>The POC did not include required DME equipment.</p> <p>3. Patient #4 was a 61 year old male who was admitted to the agency on 3/15/11 for skilled nursing, physical therapy, and home health aide services primarily related to diabetes and wound care. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 5/14/11 to 7/12/11 did not include a walker and foam wedge as DME.</p>	G 159		

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G 159	<p>Continued From page 6</p> <p>During a home visit on 6/14/11 at 4:30 PM to observe a session with his Physical Therapist, Patient #4 discussed his use of the walker. Patient #4 stated he was able to use the walker for brief periods during the day. He was observed during his therapy to use a foam wedge for elevation of his lower extremities to reduce edema. Both items had not been included as DME in the POC.</p> <p>During the home visit, the Physical Therapist confirmed Patient #4 had been using the equipment and confirmed they had not been included in the POC as DME.</p> <p>The POC did not include required DME equipment.</p> <p>4. Patient #8 was a 74 year old female admitted to the agency on 4/02/11 for skilled nursing and therapy services related to wound care and recovery from a fractured hip. The "Recertification or Other Follow-Up," completed by an RN on 5/31/11 at 1:55 PM, stated Patient #8 lived alone. The recertification also included documentation that Patient #8 had lost 5 pounds from the previous certification period. The section "Neuro, Emotional, Behavioral/Psychosocial, Spiritual" stated Patient #8 was discouraged, and had long term depression. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 6/01/11 to 7/30/11 did not include a diagnosis of depression, alteration in nutrition, or list a cane, bedside commode, and bed rail as DME.</p>	G 159		

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G 159	<p>Continued From page 7</p> <p>During a home visit on 6/15/11 at 1:30 PM to observe a session with her Occupational Therapist, Patient #8 was learning to walk with a cane. It was observed that Patient #8 had a bedside commode, as well as a bed rail. The items had not been included in the POC.</p> <p>During the home visit, the Occupational Therapist confirmed Patient #8 had been using the equipment and confirmed they had not been included in the POC as DME.</p> <p>According to the Centers for Disease Control Body Mass Index calculator, Patient #8 had a BMI of 17.5, which was considered by the CDC to be underweight. The normal weight for her height of 5'5" was listed as 112 to 150 pounds.</p> <p>In an interview with the Nurse Manager on 6/16/11 at 4:30 PM, she reviewed the record and confirmed the documentation of weight loss and lack of DME listed on the POC. The Nurse Manager stated she would have expected nutrition to be addressed as Patient #8 was on oxygen, and was receiving skilled nursing services for wound care. The Nurse Manager stated the RN had documented Paxil to be effective for Patient #8's depression.</p>	G 159		
G 160	<p>484.18(a) PLAN OF CARE</p> <p>If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan.</p>	G 160		

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G 160	<p>Continued From page 8</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to consult with the physician to authorize additional orders after an initial assessment was completed for 4 of 16 patients (#2, #3, #9, and #12) whose records were reviewed. This resulted in the provision of care without physician approval. Findings include:</p> <p>1. Patient #2 was a 69 year old male admitted to the agency on 5/11/11 for care primarily related to rehabilitation after a hip replacement.</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 5/11/11 to 7/09/11, included evaluate and treat orders for PT and OT. The orders for therapy services did not include frequency, modality, or duration. A fax was sent to the physician with the treatment plans for each discipline as evaluations were made. Nursing and home health aide orders were signed prior to their next visits.</p> <p>OT sent a "FAXED PHYSICIAN ORDERS," dated 5/12/11, which was signed by the physician on 5/31/11. Visits were made by OT before physician approval on 5/16/11, 5/18/11, 5/23/11, and 5/25/11.</p> <p>A "FAXED PHYSICIAN ORDERS" form was not sent by PT. No orders were found approving PT's POC based on the initial PT evaluation. On 6/09/11, PT requested approval for new orders on a "Physician Interim Orders" form, which was signed by the physician on 6/10/11. Visits had been made by PT before physician approval on</p>	G 160		

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G 160	<p>Continued From page 9 5/17/11, 5/19/11, 5/24/11, 5/31/11, and 6/02/11.</p> <p>On 6/16/11 at 9:45 AM, the Nurse Manager reviewed Patient #2's record and confirmed PT did not have orders for treatment after the initial evaluation. She confirmed 6/10/11 was the first documented time the physician approved the PT POC. She further confirmed OT's orders had not been signed until 5/31/11.</p> <p>The agency did not ensure the physician had approved additional PT visits, after the initial evaluation had been completed, until PT requested new orders.</p> <p>2. Patient #12 was a 48 year old female admitted to the agency on 5/16/11 for care primarily related to rehabilitation.</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 5/16/11 to 7/14/11, included evaluate and treat orders for PT and OT. The orders for therapy services did not include frequency, modality, or duration. A fax was sent to the physician with the treatment plans for each discipline as evaluations were made.</p> <p>OT sent a "FAXED PHYSICIAN ORDERS," dated 5/17/11, which was signed by the physician on 5/23/11. A visit was made by OT before physician approval on 5/18/11.</p> <p>PT sent a "FAXED PHYSICIAN ORDERS," dated 5/20/11, which was signed by the physician on 6/06/11. Visits were made by PT before physician approval on 5/24/11, 5/27/11, and 5/31/11.</p>	G 160		

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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 160	<p>Continued From page 10</p> <p>On 6/16/11 at 9:45 AM, the Nurse Manager reviewed Patient #12's record and confirmed that 5/23/11 was the first documented physician signature for the OT POC. She further confirmed that 6/06/11 was the first documented physician signature for the PT POC.</p> <p>The agency did not ensure the physician had approved additional OT and PT visits after the initial evaluations had been completed.</p> <p>3. Patient #9 was a 3 year old female admitted to the agency on 5/25/11 for care primarily related to epilepsy.</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 5/25/11 to 7/23/11, included evaluate and treat orders for PT, OT, and ST. The orders for therapy services did not include frequency, modality, or duration. A fax was sent to the physician with the treatment plans for each discipline as evaluations were made.</p> <p>PT sent a "FAXED PHYSICIAN ORDERS," dated 5/26/11, which was signed by the physician on 6/15/11. Visits were made by PT without physician approval on 6/02/11 and 6/09/11.</p> <p>On 6/16/11 at 9:45 AM, the Nurse Manager reviewed Patient #9's record and confirmed that 6/15/11 was the first documented physician signature for the PT POC.</p> <p>The agency did not ensure the physician had approved additional PT visits after the initial evaluation had been completed.</p>	G 160			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 160	Continued From page 11  4. Patient #3 was a 65 year old male admitted to the agency on 3/01/11 for care primarily related to left-sided paralysis from a stroke.  The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 4/30/11 to 6/28/11, was generated following a nursing recertification visit on 4/27/11. The POC included evaluate and treat orders for PT, OT, and ST. The orders for therapy services did not include frequency, modality, or duration. A fax was sent to the physician with the treatment plans for each discipline as evaluations were made.  ST sent a "FAXED PHYSICIAN ORDERS," dated 4/28/11, which was signed by the physician on 5/03/11. Visits were made by ST before physician approval on 5/01/11 and 5/02/11.  On 6/16/11 at 9:45 AM, the Nurse Manager reviewed Patient #3's record and confirmed ST made two visits prior to receiving approval. She stated the first documented physician signature for the ST POC was on 5/03/11.  The agency did not ensure the physician had approved additional ST visits after the initial evaluation had been completed.	G 160			
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.	G 337			

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G 337	<p>Continued From page 12</p> <p>This STANDARD is not met as evidenced by: Based on interview and review of medical records, it was determined the agency failed to ensure patient medication lists were updated and a comprehensive medication assessment was completed for 4 of 16 patients (#1, #5, #7, and #13) whose records were reviewed. Failure to obtain an accurate patient medication list or to evaluate the list for duplicative therapy, drug interactions, or significant side effects had the potential to place patients at risk for adverse events or negative drug interactions. Findings include:</p> <p>In an interview on 6/16/11 beginning at 3:00 PM, the Nurse Manager described the process of Medication Review. She stated the agency did not have a policy specific to the RN responsibility for the review of medications during the SOC, resumption, recertification, or during patient visits. The Nurse Manager stated it was the agency expectation that by signing the "Client Medication List" "Reviewed for Contraindications" section, the RN was indicating the patient medications list had been reviewed for drug interactions, side effects, and duplicative therapy. She stated the RN staff used multiple resources for drug reference information.</p> <p>1. Patient #5 was a 55 year old female with a SOC of 1/26/11 for nursing services related to wound care. The "Client Medication List," dated 5/31/11, as well as the "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the period 5/26/11 to 7/24/11 included the following medications that had been discontinued or changed:</p>	G 337			

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G 337	<p>Continued From page 13</p> <p>a. Whey protein, 24 grams/packet daily b. Novolog sliding scale c. Lantus 18 units every morning</p> <p>During a home visit on 6/15/11 beginning at 9:00 AM, the RN was observed to provide wound care and obtained Patient #5's vital signs. The RN did not do a review of medications with Patient #5.</p> <p>At 10:20 AM after the RN had completed her visit, Patient #5 spoke with the surveyor about her medications. She stated she had not taken the whey protein for more than 2 months, which was before the current certification period had started. Patient #5 stated she was taking Humalog, not Novolog sliding scale insulin, and her Lantus dose was 17 units every morning.</p> <p>In an interview on 6/16/11 at 5:00 PM, the Nurse Manager reviewed the record and was unable to explain why the medication list for Patient #5 had not been updated.</p> <p>Patient medication list was not updated.</p> <p>2. Patient #1 was a 13 year old male with a SOC of 1/08/09 for nursing and therapy services related to cerebral palsy and frequent respiratory infections. The "Client Medication List," dated 6/16/11 as well as the "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the period 4/26/11 to 6/24/11 included oxygen at a continuous flow of 2 liters per minute.</p> <p>During a home visit on 6/14/11 at 9:00 AM, Patient #1 was observed to not be on oxygen. His mother stated she would place Patient #1 on</p>	G 337		

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G 337	<p>Continued From page 14</p> <p>oxygen when he needed it and remove the oxygen when he did not need it any longer.</p> <p>In an interview on 6/16/11 at 9:20 AM, the RN who provided care for Patient #1 reviewed the record and confirmed the oxygen was listed as continuous. She stated the mother of Patient #1 would adjust the oxygen for her child. She stated the mother was sensitive to the needs of her son and would place him on oxygen when it was needed. The RN stated she did not want to get an order from the physician each time the oxygen needs of her patient changed.</p> <p>Oxygen was on the medication list as continuous although patient was on it "as needed."</p> <p>3. Patient #13 was a 66 year old female with a SOC of 5/06/11 for nursing and therapy services related to muscle weakness and end stage renal disease. The "Client Medication List," dated 6/08/11, was signed, although the section "Reviewed for Contraindications" with a line to be initialed, was left blank.</p> <p>In an interview on 6/16/11 at 3:15 PM, the Nurse Manager stated she had signed the "Client Medication List." She stated her signature indicated she had reviewed the medications listed during the SOC and the "Client Medication List" was correct. The Nurse Manager confirmed the medication list had not been reviewed for contraindications, as it had not been signed or initialed.</p> <p>The patient medications had not been reviewed by an RN for contraindications.</p>	G 337			

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G 337	<p>Continued From page 15</p> <p>4. Patient #7 was a 73 year old male admitted to the agency on 5/29/11 for care primarily related to diabetic foot ulcers and bone cancer with metastasis to the lungs.</p> <p>The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 5/29/11 to 7/27/11, included a list of medications Patient #7 was on at SOC on 5/29/11. The medication list included oxygen 3-4 liters/minute continuously.</p> <p>The "FAXED PHYSICIAN INTERIM ORDERS" as well as the "Start or Resumption of Care" form, both dated by the RN on 5/29/11, documented Patient #7 with an oxygen saturation of 97% on room air. The "Start or Resumption of Care" form dated by the RN documented Patient #7 was on oxygen at 2 liters/minute at night.</p> <p>During a home visit on 6/15/11 from 10:10 AM to 11:30 AM, Patient #7 stated he did not use oxygen during the day. He stated he used oxygen at 2 liters/minute each night.</p> <p>Immediately following the home visit on 6/15/11, Patient #7's nurse stated she knew about Patient #7's oxygen use. When asked about the POC's order for oxygen 3-4 liters/minute continuously, the nurse stated that Patient #7 had the option to use oxygen at 3-4 liters/minute if he needed it, but otherwise, he was on room air during the day.</p> <p>The agency did not ensure Patient #7's comprehensive medication review was accurate to what he was actually using.</p> <p>The agency did not ensure medications were</p>	G 337		

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G 337	Continued From page 16 reviewed for changes, contraindications, or side effects during home visits, or when certification assessments were done.	G 337			

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N 000	16.03.07 INITIAL COMMENTS  The following deficiencies were cited during the state survey of your agency. The surveyors conducting the survey were:  Karen Robertson, RN, BS, HFS, Team Leader Susan Costa, RN, HFS  Acronyms used in this report include:  DME - Durable Medical Equipment POC - Plan of Care	N 000	<p>Please refer to attached PoC for Tags 062, 153, 154, 155, 160, 170, 173.</p> <p>Linda Karlgaard, Nurse Manager   RN, BS, HFS                      7/8/11</p>	11 10
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 G-0144 as it relates to coordination of care between the disciplines providing care for the patient.	N 062		
N 153	03.07030.PLAN OF CARE  N153 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes:	N 153		

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TITLE

(X6) DATE

7/5/11

Bureau of Facility Standards

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N 153	Continued From page 1  a. All pertinent diagnoses;  This Rule is not met as evidenced by: Refer to G-0156 as it relates to written POCs which include pertinent diagnoses.	N 153		
N 154	03.07030.PLAN OF CARE  N154 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:  b. The patient's mental status;  This Rule is not met as evidenced by: Refer to G-0159 as it relates to POCs which include patients' mental status.	N 154		
N 155	03.07030. PLAN OF CARE  N155 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes:  c. Types of services and equipment required;  This Rule is not met as evidenced by: Refer to G-0159 as it relates to POCs which include DME.	N 155		

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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: Refer to G-0159 as it relates to POCs which include nutritional requirements.	N 160		
N 170	03.07030.04.PLAN OF CARE  N170 04. Initial Plan of Care. The initial plan of care and subsequent changes to the plan of care are approved by a doctor of medicine, osteopathy, or podiatric medicine.  This Rule is not met as evidenced by: Refer to G-016 as it relates to physician approval of changes to the POC.	N 170		
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	N 173		

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N 173	Continued From page 3  laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician.  This Rule is not met as evidenced by: Refer to G-1337 as it relates to review of all patient medications.	N 173		



Public Health  
Panhandle Health District

**PANHANDLE HEALTH DISTRICT 1  
HOME HEALTH DIVISION**  
*Compassionate Care is What We Do Best*  
~ Since 1966 ~

**BUREAU OF FACILITY STANDARD  
PLAN OF CORRECTION  
JULY 2011**

**G 144 & N 062**

- Action:
  - Review with all staff and contractors, at July 2011 nurse's and team conference meetings, the importance of care coordination and completing the care coordination component of all discipline intervention forms every time discussion and/or communication takes place on multidisciplinary cases.
  - Review Team Conference procedures and forms at July 2011 nurse's and team conference meetings.
  - Communication will be documented on a "Communication" form when barriers to progress, changes in medications, etc. occur that need to be coordinated between disciplines. Person initiating conversation will document conversation.
- Monitoring & persons responsible: Linda Karlgaard, Nurse Manager and Joyce Bergen, OBQI Coordinator
  - Nurse Manager and OBQI Coordinator will complete monthly chart audits. All skilled services will participate in quarterly monitoring. OBQI coordinator will compile results and share report with all staff quarterly.
  - The following will be added to the monthly and quarterly chart audit form:
    - Look at team conference section, communication notes, OASIS, and visit notes (Coordination of Care sections): Is there evidence of communication between/among disciplines if the patient is receiving more than one skilled service?
- Completion date: 09/01/11
- Process improvement: the above will ensure documentation of coordination of patient care. Monitoring will show 90% to 100% compliance, on an ongoing basis.

**See attached:** *new templates of PT, OT, ST visit notes,, Communication slip, Scope of Services Policy, Coordination of Patient Care Procedure, and Team Conference Procedure, Monthly and Quarterly Audit forms, Agenda for July Nurse's meeting and Team Conference.*

## G 159 & N153, N154, N155, N160

- Action:
  - During the admission assessment, RN Case Managers will evaluate patient's history, diagnoses, current medications, review of systems including mental status and nutritional requirements. Medications will be tied to specific diagnoses and will be documented as such. When follow-up assessments are completed, RN Case Manager will review the SOC to ensure consistency with the above.
  - DME: RN Case Manager is responsible to communicate/coordinate with therapists to record all DME used by the patient/family with every SOC and Recertification. RN Case Manager is to check prior Oasis assessment to ensure accurate documentation of DME.
  - Review with all staff and therapists at July 2011 meetings that current medications ordered will correspond to pertinent diagnoses listed on the SOC and Recertification, and that all DME is accurately recorded.
- Monitoring & persons responsible: Linda Karlgaard, Nurse Manager and Joyce Bergen, OBQI Coordinator
  - Nurse Manager and OBQI coordinator will complete monthly chart audits. All skilled services will participate in quarterly monitoring. OBQI coordinator will compile results and share report with all staff quarterly.
  - The following will be added to the monthly and quarterly chart audit form:
    - Check SOC and Recertification for consistency in documentation of all DME
    - Check SOC and Recertification is there a diagnosis that corresponds to medications patient is taking?
- Completion date: 09/01/11
- Process improvement: the above will ensure accuracy in documentation of all DME used by patient in the home and medications will be consistent with pertinent diagnoses. Monitoring will show 90 to 100% compliance, on an ongoing basis..

**See attached:** *Monthly and Quarterly Audit forms, Agendas for July Nurse's meeting and Team Conference*

## G 160 & N170

- Actions:
  - In initial admission order from the physician, the word “treat” will be deleted from the order (e.g. PT: eval and tx) only an Evaluation will be done without further orders from the physician.
  - It is the responsibility of the therapist to call in interim orders to Nurse Manager within 48-hours of seeing patient and before initiating their plan of care.
  - If interim orders have not been received, signed and dated by physician before first treatment visit, therapist is to call and receive verbal order or wait to make the visit until signed order is received.
- Monitoring & person responsible: Linda Karlgaard, Nurse Manager and Joyce Bergen, OBQI Coordinator
  - Nurse Managers and OBQI Coordinator will complete monthly chart audits. All skilled services will participate in quarterly monitoring. OBQI coordinator will compile results and share report with all staff quarterly.
  - The following will be added to the monthly and quarterly chart audit form:
    - Look at therapy interim orders: Were treatment visits made before the date of signed MD order?
- Completion date: 08/01/11
- Process improvement: the above will ensure all therapy treatment visits will not take place prior to receiving signed MD Orders. Monitoring will show 90 to 100% compliance, on an ongoing basis.

***See attached:*** *Contractor's Interim Order Procedure, revised Monthly and Quarterly Audit forms, Agendas for Nursing and Team Conference meetings*

## G 337 & N173

- Action:
  - Review with all staff and therapists at July 2011 nurse's and team conference meetings:
    - Revisions on Medication List Document Procedure
    - Revisions on Medication Changes for Therapy Patients Procedure
    - RN Case Manager and therapists responsibility to review medications with patient at every visit for the following ~
      - To identify:
        - any potential adverse effect and drug reaction(s)
        - ineffective drug therapy
        - significant side effect
        - significant drug interaction
        - duplicate drug therapy
        - non-compliance with drug therapy
      - To contact physician as needed.
    - Revision of intervention forms for nursing (generic and Home Health Aide Supervision) and therapy to include:
      - Template on to each form the following:
        - Medication: Med change since last visit    Yes    No
        - Reconciliation
        - Med Profile Updated
        - Contraindications Checked
    - Explore the purchase of an electronic medication reconciliation package from our current software provider
  - Monitoring & person responsible: Linda Karlgaard, Nurse Manager and Joyce Bergen, OBQI Coordinator
    - Nurse Managers and OBQI Coordinator will complete monthly chart audits. All skilled services will participate in quarterly monitoring. OBQI Coordinator will compile results and share report with all staff quarterly.
    - The following will be added to the monthly and quarterly chart audit form:
      - Look at visit notes, communication notes: Is there documentation that medications were reviewed at each visit?
      - Look at orders: If new medication(s) has been added since SOC or Recertification, is there an order for new medication(s)?
      - Look at OASIS SOC/ROC #128-129 and orders: If problem(s) is found during drug review, is there documentation of contact with MD to reconcile the problem(s)?
  - Completion date: 09/01/11
  - Process improvement: the above will ensure medication reconciliation is occurring at every visit. Monitoring will show 90 to 100% compliance, on an ongoing basis.

**See attached:** *Medication List Documentation, Medication Changes for Therapy Patients Procedures, Coordination of Patient Care Procedure, and new templates of PT, OT, ST, Generic Nursing and Home Health Aide Supervisory visit notes, revised Monthly and Quarterly Audit forms, Agendas for nursing and team conference meetings.*