DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

August 10, 2011

Mary Lou Long, RN, MSN, NHA
Director Community Services, Home Care and Hospice
St Luke's Home Care and Hospice
190 East Bannock Street
Boise, ID 83712

CMS Certification Number: 13-7028

Re: Plan of Correction Received

Dear Ms. Long:

The Centers for Medicare and Medicaid Services (CMS) has received St Luke's Home Care's voluntarily submitted plan of correction following the July 14, 2011, sample validation survey. CMS appreciates the time and effort of you and staff in developing and implementing the plan of correction. Please contact me at (206) 615-2432 or Catherine.mitchell@cms.hhs.gov if you need further information.

Sincerely,

Kate Mitchell

Kate Mitchell, Health Insurance Specialist
Survey, Certification, and Enforcement Branch - Seattle

cc: Sylvia Creswell, Idaho Bureau of Facility Standards

St Luke's
Home Care
and Hospice

August 5, 2011

Kate Mitchell, Division of Survey and Certification
Center for Medicare and Medicaid Services
2201 Sixth Avenue, Mail Stop RX-48
Seattle, Washington 98121

Sylvia Creswell, Supervisor
Idaho Bureau of Facility Standards – DHW
P.O. Box 83720
Boise, ID 83720-0036

RE: St. Luke's Boise Home Care #137028

Dear Ms. Mitchell and Ms. Creswell:

Enclosed is our Plan of Correction for our validation survey completed on July 14, 2011. Because we are a Joint Commission accredited organization and currently have deemed status, we understand a Plan of Correction is not required. However, we have determined it appropriate to respond to the deficiencies cited.

We appreciated the professionalism and courtesy of the surveyors. If you have any questions, please call 381-3946.

Sincerely,

Mary Lou Long, RN, MSN, NHA
Director Community Services, Home Care and Hospice

cc: Pam Bernard
Mary Cronin

RECEIVED
AUG 0 8 2011
FACILITY STANDARDS

190 East Bannock Street
Boise, Idaho 83712
P (208) 381-2138 F (208) 381-2725

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
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IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 25, 2011

Mary Lou Long, Director
St Luke's Home Care
325 West Idaho Street
Boise, ID 83702

CMS Certification Number: 13-7028

Re: Results of Sample Validation Survey

Dear Ms. Long:

The Centers for Medicare and Medicaid Services (CMS) is confirming the results of the sample validation survey, completed by the Idaho Bureau of Facility Standards (State survey agency) on July 14, 2011, at St Luke's Home Care.

CMS finds that your home health agency is in compliance with all the Medicare Conditions of Participation and will continue to be certified as meeting Medicare requirements. We have forwarded a copy of this letter and the findings from the survey to the Joint Commission.

It is not a requirement to submit a plan of correction; however, under federal disclosure rules, findings of the inspection, including the plan of correction submitted by the facility, become publicly disclosable if requested within ninety days of completion.

You may therefore wish to submit your plans for correcting the deficiencies cited. An acceptable plan of correction contains the following elements:

- The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited.
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited.
- The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements.
- A completion date for correction of each deficiency cited must be included.
- The title of the person responsible for implementing the acceptable plan of correction.

Please send a copy of your plan of correction within 10 days receipt of this letter to CMS and the State survey agency. **If you choose to not submit a plan a correction, please sign and date the first page of Form CMS-2567 and return to CMS.**

Kate Mitchell, Division of Survey and Certification
Centers for Medicare and Medicaid Services
2201 Sixth Avenue, Mail Stop RX-48
Seattle, Washington 98121

And

Sylvia Creswell, Supervisor
Idaho Bureau of Facility Standards - DHW
PO Box 83720
Boise, ID 83720-0036

We thank you for your cooperation, and look forward to working with you on a continuing basis in the administration of the Medicare program. Please contact me at (206) 615-2432 or by e-mail Catherine.mitchell@cms.hhs.gov if you need additional information.

Sincerely,

Kate Mitchell

Kate Mitchell, Health Insurance Specialist
Survey, Certification and Enforcement Branch – Region 10

Enclosure

cc: Idaho Bureau of Facility Standards
CMS Central Office
Joint Commission

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

July 26, 2011

Mary Lou Long, Administrator
St Lukes RMC Home Care
190 East Bannock
Boise, ID 83712

RE: St Lukes RMC Home Care, Provider #137028

Dear Ms. Long:

This is to advise you of the findings of the Medicare/Licensure validation survey at St Lukes RMC Home Care, which was concluded on July 14, 2011.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, 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 hospital into compliance, and that the hospital 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 State Form.

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

August 8, 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,

SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/srm
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137028	A. BUILDING _____ B. WING _____	07/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES RMC HOME CARE	325 WEST IDAHO BOISE, ID 83712

(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 Validation survey of your agency. The surveyors conducting the survey were: Susan Costa, RN, HFS, Team Leader Karen Robertson, RN, BS, HFS Gary Guiles, RN, HFS Acronyms used in this report include: CPAP - Continuous Positive Airway Pressure DME - Durable Medical Equipment Gm - gram ml - milliliter Na - sodium NPO - nothing by mouth POC - Plan of Care	G 000		
G 114	484.10(e)(1(i-iii) PATIENT LIABILITY FOR PAYMENT Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to pay. This STANDARD is not met as evidenced by: Based on staff interview, and record review, it was determined the agency failed to inform patients in writing of expected financial liability or lack thereof for 11 of 20 patients (#3, #4, #5, #6, #8, #9, #12, #14, #16, #17, and #19) whose	G 114		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Director of Home Care	8/5/11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 114	Continued From page 1 records were reviewed. This had the potential to interfere with patients' ability to make informed decisions about accepting or declining agency services based on financial considerations. It also resulted in patients, who may have been told verbally by agency staff about potential financial responsibility, not receiving a written reminder. Findings include: In an interview on 7/12/11 at 3:00 PM, the Business Manager reviewed the "Patient Financial Responsibility" form. He stated the admission nurse would discuss the financial liability information with the patient before it was signed, and would explain to the patient that Medicare and Medicaid would be accepted as payment in full and the patient would not receive a bill. The Business Manager acknowledged the form for Medicare patients was not completed to provide written notice of that information, but would instead be left blank per agency practice. In a follow-up interview on 7/15/11 at 10:00 AM, the Clinical Educator stated if the patient had Medicare, the agency practice was to include on the form the policy number, patient signature, and date, but to leave the remainder of the form blank. She stated by leaving the form blank, the agency was indicating the patient did not have any expected financial liability. She stated she agreed their practice did not actually show in writing what the patient's financial responsibility was. The following are examples of patients not being informed in writing of their financial responsibility: a. Patient #4 was a 76 year old female admitted	G 114	G114 The financial responsibility form was modified to make it clearer to patients what their financial liability (if any) would be. The form was modified prior to the survey but not in use at the time of the survey. The form will be presented to staff at staff meetings on August 8th and 9th by the clinical educator. Education will be completed by the clinical educator in education sessions to Home Care nurses and therapists from August 10th through August 31st. The PI/Education Manager (or designee) will audit all new patient charts after September 1st ongoing for two months and then will add review of the financial form completion as part of the open/closed chart audit process done by the medical records clerk on all records.	Education will be completed 8/31/11, and audits 10/31/11.

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G 114	Continued From page 2 to the agency on 4/29/11, for care primarily related to aftercare of a left total hip replacement. In a review of the medical record, a form titled "Patient Financial Responsibility," dated 4/29/11 and signed by Patient #4, was used to show Patient #4's insurance coverage and expected financial liability. The form was pre printed and included blank areas to be filled in which would provide the patient with information regarding the deductible, and if it had been met, the amount the insurance would pay. It would also show the patient out of pocket expense, if any. The blank areas of the form were not completed to provide information to Patient #4 regarding her financial liability. There was no documentation found in the medical record to indicate Patient #4 had been informed in writing of the extent to which payment may be required. In an interview on 7/15/11 at 1:30 PM, the Clinical Educator reviewed Patient #4's record and agreed the "Patient Financial Responsibility" form did not state what her expected payments would be. b. Patient #5 was a 95 year old female admitted to the agency on 6/14/11, for care primarily related to pneumonia. In a review of the medical record, a form titled "Patient Financial Responsibility," dated 6/14/11 and signed by Patient #5, was used to show Patient #5's insurance coverage and expected financial liability. The form was pre printed and included blank areas to be filled in which would	G 114		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES RMC HOME CARE	325 WEST IDAHO BOISE, ID 83712

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G 114	Continued From page 3 provide the patient with information regarding the deductible, and if it had been met, the amount the insurance would pay. It would also show the patient out of pocket expense, if any. The blank areas of the form were not completed to provide information to Patient #5 regarding her financial liability. There was no documentation found in the medical record to indicate Patient #5 had been informed in writing of the extent to which payment may be required. In an interview on 7/15/11 at 1:30 PM, the Clinical Educator reviewed Patient #5's record and agreed the "Patient Financial Responsibility" form was filled out per agency practice and did not state what her expected payments would be. c. Patient #12 was an 89 year old female admitted to the agency on 6/09/11, for care primarily related to aftercare of a traumatic forearm fracture. In a review of the medical record, a form titled "Patient Financial Responsibility," dated 6/09/11 and signed by Patient #12, was used to show Patient #12's insurance coverage and expected financial liability. The form was pre printed and included blank areas to be filled in which would provide the patient with information regarding the deductible, and if it had been met, the amount the insurance would pay. It would also show the patient out of pocket expense, if any. The blank areas of the form were not completed to provide information to Patient #12 regarding her financial liability.	G 114		

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G 114	Continued From page 4 There was no documentation found in the medical record to indicate Patient #12 had been informed in writing of the extent to which payment may be required. In an interview on 7/15/11 at 1:30 PM, the Clinical Educator reviewed Patient #12's record and agreed the "Patient Financial Responsibility" form was filled out per agency practice and did not state what her expected payments would be. d. Patient #16 was a 6 year old male admitted to the agency on 6/02/11, for care primarily related to tracheostomy care and failure to thrive. In a review of the medical record, a form titled "Patient Financial Responsibility," dated 6/02/11 and signed by Patient #16's mother, was used to show Patient #16's insurance coverage and expected financial liability. The form was pre printed and included blank areas to be filled in which would provide the patient with information regarding the deductible, and if it had been met, the amount the insurance would pay. It would also show the patient out of pocket expense, if any. The blank areas of the form were not completed to provide information to Patient #16 regarding his financial liability. There was no documentation found in the medical record to indicate Patient #16 had been informed in writing of the extent to which payment may be required. In an interview on 7/15/11 at 1:30 PM, the Clinical Educator reviewed Patient #16's record and stated for patients with Medicaid, a box should have been checked which stated Medicaid would	G 114		

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G 114	Continued From page 5 be accepted as payment in full. She agreed the box was not checked on Patient #16's "Patient Financial Responsibility" form and therefore it did not state what his expected payments would be. e. Patient #17 was a 59 year old female admitted to the agency on 3/02/11, for care primarily related to multiple sclerosis and care of a cystostomy (an opening to the bladder). In a review of the medical record, a form titled "Patient Financial Responsibility," dated 3/01/11 and signed by Patient #17, was used to show Patient #17's insurance coverage and expected financial liability. The form was pre printed and included blank areas to be filled in which would provide the patient with information regarding the deductible, and if it had been met, the amount the insurance would pay. It would also show the patient out of pocket expense, if any. The blank areas of the form were not completed to provide information to Patient #17 regarding her financial liability. There was no documentation found in the medical record to indicate Patient #17 had been informed in writing of the extent to which payment may be required. In an interview on 7/15/11 at 1:30 PM, the Clinical Educator reviewed Patient #17's record and agreed the "Patient Financial Responsibility" form was filled out per agency practice and did not state what her expected payments would be. f. Patient #3 was a 63 year old male admitted to the agency on 6/26/11, for nursing and physical therapy services related to a hip fracture.	G 114		

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G 114	Continued From page 6 The form titled "Patient Financial Responsibility," dated 6/26/11 and signed by Patient #3, included documentation of his medical insurance. The form was pre printed and included blank areas to be filled in which would provide the patient with information regarding the deductible, and if it had been met, the amount the insurance would pay. It would also show the patient out of pocket expense, if any. The blank areas of the form were not completed to provide information to Patient #3 regarding his financial liability. In an interview on 7/12/11 at 2:25 PM, the Clinical Educator stated during the admission process, the nurse would inform the patient that his insurance would be billed, but no bill would be sent to him. g. Patient #6 was a 91 year old female admitted to the agency on 5/21/11, for care primarily related to wound care. The form titled "Patient Financial Responsibility," dated 5/21/11 and signed by Patient #6, included documentation of her medical insurance. The form was pre printed and included blank areas to be filled in which would provide the patient with information regarding the deductible, and if it had been met, the amount the insurance would pay. It would also show the patient out of pocket expense, if any. The blank areas of the form were not completed to provide information to Patient #6 regarding her financial liability. In an interview on 7/12/11 at 3:00 PM, the Business Manager reviewed the "Patient Financial Responsibility" form, and stated the	G 114		

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G 114	Continued From page 7 admission nurse would discuss the financial liability information with the patient before it was signed, and would explain to the patient that Medicare would be accepted and the patient would not receive a bill. The Business Manager acknowledged the form had not been completed to provide written notice of that information. The "Patient Financial Responsibility" form was incomplete, and the patient was not provided with written information regarding financial liability. h. Patient #8 was a 3 month old female admitted to the agency on 5/16/11, with a diagnosis of microcephaly. She was currently a patient as of 7/14/11. The medical record contained a form titled "Patient Financial Responsibility." It was signed by Patient #8's mother on 5/16/11. The form stated "Billing will be based on the services provided by the agency." The form included a list of charges which had been circled by hand for various services, including rates for nursing visits, a rate for different therapy visits, and rates for social services. In addition, the form stated Patient #8 would "...receive an itemized invoice for supplies each time they are delivered." The form did not include the cost of supplies. The Clinical Educator, interviewed on 7/12/11 at 2:30 PM, confirmed the form did not accurately state Patient #8's financial liability. There was no documentation found in the medical record to indicate Patient #8 had been informed in writing of the extent to which payment might have been required.	G 114		

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G 114	Continued From page 8 i. Patient #9 was a 54 year old female admitted to the agency on 7/01/11, for therapy after falling at home. She also had a diagnosis of galactosemia, a rare genetic metabolic disorder. She was currently a patient as of 7/14/11. The medical record contained a form titled "Patient Financial Responsibility." It was signed by Patient #9 and dated 7/01/11. The form stated "Billing will be based on the services provided by the agency." The form included a list of charges for various services, such as a rate for nursing visits, a rate for different therapy visits, etc. In addition, the form stated Patient #9 would "...receive an itemized invoice for supplies each time they are delivered." The form did not include the cost of supplies. The Clinical Educator, interviewed on 7/14/11 at 9:20 AM, confirmed the form did not accurately state Patient #9's financial liability. There was no documentation found in the medical record to indicate Patient #9 had been informed in writing of the extent to which payment might have been required. j. Patient #14 was an 82 year old female admitted to the agency on 6/28/11, for therapy after falling at home. She was currently a patient as of 7/14/11. The medical record contained a form titled "Patient Financial Responsibility." It was signed by Patient #14 and dated 6/28/11. The form stated "Billing will be based on the services provided by the agency." The form included a list	G 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 114	Continued From page 9 of charges for various services, such as a rate for nursing visits, a rate for different therapy visits, etc. In addition, the form stated Patient #14 would "...receive an itemized invoice for supplies each time they are delivered." The form did not include the cost of supplies. The Clinical Educator, interviewed on 7/14/11 at 9:20 AM, confirmed the form did not accurately state Patient #14's financial liability. There was no documentation found in the medical record to indicate Patient #14 had been informed in writing of the extent to which payment might have been required. k. Patient #19 was an 88 year old female admitted to the agency on 5/11/11, for a wound on her left leg. She was currently a patient as of 7/14/11. The medical record contained a form titled "Patient Financial Responsibility." It indicated verbal consent by Patient #19's guardian on 5/11/11. The form stated "Billing will be based on the services provided by the agency." The form included a list of charges for various services, such as a rate for nursing visits, a rate for different therapy visits, etc. In addition, the form stated Patient #19 would "...receive an itemized invoice for supplies each time they are delivered." The form did not include the cost of supplies. The Clinical Educator, interviewed on 7/14/11 at 9:20 AM, confirmed the form did not accurately state Patient #19's financial liability. The agency did not inform patients in writing of	G 114		

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G 114	Continued From page 10 payment coverage for federally funded programs and charges they may have to pay.	G 114		
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, and patient interview, it was determined the agency failed to ensure plans of care covered all pertinent information for 1 of 20 patients (#2) whose records were reviewed. This had the potential to negatively impact quality, coordination, and completeness of patient care. Findings include: 1. Patient #2 was a 60 year old male who was admitted to the agency on 6/11/11 for care related to post operative rehabilitation. The "PLAN OF CARE" for the certification period 6/11/11 to 8/09/11, included the following discrepancies when compared with the physician referral orders, admission assessment, and patient record: - Referral orders, dated 6/11/11, included orders for tube feeding of 2160 ml / 24 hours and 60 ml of water six times daily. The referral also	G 159	G 159 8/3/11--the business manager contacted our electronic medical record company (Thornberry) to work with them on making sure any orders entered into the system will pull onto the plan of care (485). Education on how to modify and update the plan of care automatically generated by the system will be provided by the clinical educator to all Home Care nurses and therapists during the month of August. Plans of care will be audited by the PI/education manager and/or clinical educator for each clinician. After each clinician has correctly completed 3 plans of care, they will no longer be audited.	Education will be completed 8/31/11, and audits 10/31/11.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137028	A. BUILDING _____ B. WING _____	07/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES RMC HOME CARE	325 WEST IDAHO BOISE, ID 83712

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G 159	Continued From page 11 included orders for oxygen at 2 liters by nasal cannula. The POC did not include the tube feedings, water, or oxygen. -The POC documented the diet for Patient #2 as "4 Gm Na," (also known as no added salt, the purpose of the diet to lower blood pressure), although the admission assessment, dated 6/11/11, documented Patient #2 as being NPO, with aspiration precautions. -The admission assessment, dated 6/11/11, documented Patient #2 was on CPAP at night, although it was not on the POC. - The POC did not include tube feeding supplies, oxygen and CPAP equipment, feeding pump, and cervical neck brace as DME. - The POC did not include aspiration precautions in section 15, "Safety Measures." - The POC included nursing orders to administer wound care as ordered, although there were no wound care orders noted in the record. In an interview on 7/11/11 at 3:45 PM, the Clinical Educator reviewed Patient #2's record, and verified the inconsistencies with the POC, orders, and admission record. She confirmed the tube feedings, oxygen, and CPAP, as well as, the DME, should have been included on the POC. The Clinical Educator stated the wound care orders were part of a software program which was included for all patients that had a diagnosis of surgical procedures. She stated the wound care order should have been omitted from the POC when it was reviewed, as Patient #2 did not	G 159		

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G 159	Continued From page 12 require wound care. During a home visit on 7/13/11 at 3:00 PM, Patient #2 confirmed he was NPO when he was discharged from the hospital and started home health visits on 6/11/11. He stated he no longer required oxygen, and was able to take foods by mouth and required less tube feeding supplementation. The Plan of Care did not include pertinent information and DME equipment.	G 159		

Bureau of Facility Standards

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the Validation survey of your agency. The surveyors conducting the survey were: Susan Costa, RN, HFS, Team Leader Karen Robertson, RN, BS, HFS Gary Guiles, RN, HFS	N 000		
N 041	03.07020. ADMIN. GOV. BODY N041 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.xxi. Before the care is initiated, the HHA must inform a patient orally and in writing of the following: c) The charges that the patient may have to pay; and This Rule is not met as evidenced by: Refer to G-0114 as it refers to the failure to inform patients with written notice of expected financial liability.	N 041	N 041 The financial responsibility form was modified to make it clearer to patients what their financial liability (if any) would be. The form was modified prior to the survey but not in use at the time of the survey. The form will be presented to staff at staff meetings on August 8th and 9th by the clinical educator. Education will be completed by the clinical educator in education sessions to Home Care nurses and therapists from August 10th through August 31st. The PI/Education Manager (or designee) will audit all new patient charts after September 1st ongoing for two months and then will add review of the financial form completion as part of the open/closed chart audit process done by the medical records clerk on all records.	Education will be completed 8/31/11, and audits 10/31/11.
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:	N 155		

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FACILITY STANDARDS

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N 155	Continued From page 1 c. Types of services and equipment required; This Rule is not met as evidenced by: Refer to G-0159 as it refers to the failure of the agency to include treatments, equipment, and services on the Plan of Care.	N 155	N 155 8/3/11--the business manager contacted our electronic medical record company (Thornberry) to work with them on making sure any orders entered into the system will pull onto the plan of care (485). Education on how to modify and update the plan of care automatically generated by the system will be provided by the clinical educator to all Home Care nurses and therapists during the month of August. Plans of care will be audited by the PI/education manager and/or clinical educator for each clinician. After each clinician has correctly completed 3 plans of care, they will no longer be audited.	Education will be completed 8/31/11, and audits 10/31/11.