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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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September 8, 2011

Jennifer Davis, Administrator
Onesource Home Health
3544 East 17th Street Suite 201
Idaho Falls, ID 83406

RE: Onesource Home Health, Provider #137111

Dear Ms. Davis:

Based on the survey completed at Onesource Home Health, on August 29, 2011, by our staff, we have determined Onesource Home Health is out of compliance with the Medicare Home Health Agency (HHA) **Condition of Participation on Organization, Services & Administration (42 CFR 484.14)**. To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused this condition to be unmet, substantially limit the capacity of Onesource Home Health, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;

- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the home health agency into compliance, and that the home health agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before October 13, 2011. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than September 30, 2011.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **September 21, 2011**.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

AH/srm
Enclosures
ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Kate Mitchell, CMS Region X Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137111	A. BUILDING _____ B. WING _____	08/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONESOURCE HOME HEALTH	3544 EAST 17TH STREET SUITE 201 IDAHO FALLS, ID 83406

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G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your Home Health Agency. The following surveyors conducted the survey: Aimee Hastriter, RN, BS, HFS, Team leader Teresa Hamblin, RN, MSN, HFS Rebecca Lara, RN, BA, HFS The following acronyms were used in this report: ALF - Assisted Living Facility dl - deciliter DME - Durable Medical Equipment DON - Director of Nursing ED - Emergency Department HHA - Home Health Agency LPN - Licensed Practical Nurse mg - milligram OT - Occupational Therapy POC - Plan of Care PT - Physical Therapist PTA - Physical Therapy Assistant RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care TENS - Transcutaneous Electrical Neural Stimulation	G 000	OneSource Home Health Care, LLC Plan of Correction OneSource Home Health Care takes these problems identified of the survey completed on 8/29/11 very seriously and has taken following general overall actions to correct the problems identified and to prevent future problems. • Counseled the involved staff individually to apprise them of errors and clarify agency expectations for the future. • In-service training sessions for all staff have been completed. • The contract for therapy services was corrected to meet state and federal regulations. • Organizational chart has been amended to clearly identify lines of authority for contracted therapies. • Monitoring systems and process are in place. • The Agency has prepared a binder with the survey and plan of correction. Documents of in-service training sessions, contracts, organizational chart and QI audits are available for review. The documents in this binder will be kept available for the next site visit or to send as requested.	
G 101	484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights. This STANDARD is not met as evidenced by:	G 101	**CMS STD: G101** **CMS CFR:** 484.10 **Evidence:** The organization failed to demonstrate protection of patient's right to privacy during home visits.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jennifer Davis | Administrator

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 101	Continued From page 1 Based on observation, review of patients' rights information, and staff interview it was determined the agency failed to protect and promote a patient's right to privacy for 1 of 6 sample patients (#3) whose home visits were observed. This had the potential to result in unauthorized access to private patient information and unwanted physical exposure of a patient. Findings include: 1. The agency's "Patient Orientation For Home Health Care" booklet, revised June of 2011, was reviewed. Section 3 of the booklet contained "Patient Rights and Responsibilities." According to this documentation, patients have the right to "Personal privacy and security during home care visits..." A patient's right to privacy was not protected in the following example where a patient's door was left open during cares: a. Patient #3 was a 91 year old female admitted on 8/11/11 for care of a pressure ulcer on her left foot. Her dressing change was observed on 8/23/11 from 10:20 AM to 10:45 AM. Patient #3 resided in an ALF. A comprehensive assessment of Patient #3 was completed by an RN on 8/11/11. The RN documented Patient #3 had difficulty hearing and required the speaker to speak in a loud and distinct voice. At 10:25 AM, the RN was observed to expose Patient #3's left foot and change the dressing. Once the dressing change was completed, the RN listened to Patient #3's heart, lung, and bowel sounds. She checked Patient #3's blood pressure, temperature, and oxygen saturation level. Following the physical examination, the RN	G 101	**Agency response: What action will we take to correct the deficiency cited?** • The RN was counseled on 09/06/2011 by the DCS regarding Patient Rights and the Right to have privacy during home visits. The DCS instructed the RN on ensure the door to the patient's room in the Assisted Living Facility remains closed when completing home visits. • An in-service training session on Patient Rights and the Right to Privacy was completed for all direct care employees on 09/19/2011. (Copy of attendance and agenda available on site) **Who is responsible to implement the corrective action?** The Director of Clinical Services is responsible to ensure compliance. **When will the corrective action be implemented?** Date of Compliance: 09/19/2011. **What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action?** Compliance will be monitored by the Director of Clinical Services or designee. The DCS or designee will perform quarterly random home visits with employees to ensure compliance with following patient's right to privacy.	

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G 101	Continued From page 2 evaluated Patient #3's cognitive status by asking her a few questions. (The RN documented on the nursing visit note for 8/23/11 that Patient #3 was alert, forgetful, and not oriented to person, place, or time.) The RN asked Patient #3 how her appetite was, if she had any problems with bowel movement or urination, and if she had any pain to report. Patient #3's door remained open throughout the visit and people were observed to be moving about in the ALF hallway. The RN who provided care to Patient #3 was interviewed on 8/26/11 at 12:00 PM. When asked the intention behind leaving the door open during the visit, she reported that Patient #3 shared a room with another ALF resident who wandered in and out of the room during the day. The RN also stated in the past she had a negative experience treating a patient in a closed room and preferred not to put herself in that position again. She also stated if she needed assistance with providing care (i.e. needed an extra hand to retrieve additional equipment while she was in the middle of a dressing change) she would be able to call out for assistance without leaving the patient. She stated she did not feel that the location of Patient #3's wound, nor the basic questions related to pain and elimination, were personal enough to require the privacy of a closed door. She stated if the care to be provided to a patient involved an area of the body that required privacy, or the questions and answers were more personal, she would have closed the door. The agency did not ensure that Patient #3's right	G 101		

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G 101	Continued From page 3 to privacy was protected.	G 101		
G 118	484.12(a) COMPLIANCE WITH FED, STATE, LOCAL LAWS The HHA and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations. If State or applicable local law provides for the licensure of HHAs, an agency not subject to licensure is approved by the licensing authority as meeting the standards established for licensure. This STANDARD is not met as evidenced by: Based on record review, review of agency policies, review of state licensing rules, and staff interview it was determined the agency failed to ensure LPN and PTA supervisory visits were conducted and documented in accordance with state licensing rules. This impacted 1 of 2 sample patients (#11) who received care from an LPN and 1 of 7 sample patients (#2) who received care from a PTA. Failure to adhere to state licensing rules for supervision resulted in a delay in re-evaluating patients' needs and had the potential to result in inadequate provision of care to patients. Findings include: 1. State licensing rules for HHAs found at IDAPA 16.03.07.024.01.j, require that for "patients receiving care from a licensed practical nurse, the registered nurse reviews the plan of care and nursing services received at lease every two (2) weeks and documents this in the patient's medical record." The agency policy "LICENSED PRACTICAL NURSE SUPERVISION," undated, was reviewed.	G 118	**CMS STD: G118** **CMS CFR:** 484.12(a) **Evidence:** The organization failed to demonstrate compliance with state licensing regulations for LPN and PTA supervision. **Agency response: What action will we take to correct the deficiency cited?** • The policy for LPN supervision was amended on 09/06/2011 to reflect Idaho state licensing regulations for LPN every 14 days. (Copy of policy available on site.) • PTA supervision to be completed by the Physical Therapist PT on the 5th visit was included in the therapy contract. 09/19/2011. (Copy of contract available on site.) • An in-service training session for all direct care employees was completed on 09/06/2011. The employees were instructed on the frequency of supervision for LPNs and PTAs and reviewing LPN and PTA notes to ensure the plan of care is followed. (Copy of attendance and agenda available on site) **Who is responsible to implement the corrective action?** The Director of Clinical Services and Therapy supervisor is responsible to ensure compliance.	

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G 118	Continued From page 4 According to the policy, the RN supervisory visit may be completed directly while the LPN provided services to the patient, or indirectly by alternating visits with the LPN and RN. In addition, if an LPN provided care to a patient whose condition was unstable, or whose care plan was complex, the policy indicated, "If the LPN has demonstrated competency in and is assigned to provide care to clients with complex needs, the Registered nurse [sic] will supervise and instruct the LPN on the first day of assignment and as often as deemed necessary but no less than every thirty (30) [sic] thereafter." The agency policy did not accurately reflect the state licensing rules related to LPN supervision. LPN supervision was not provided in accordance with state licensing rules, as follows: Patient #11 was a 74 year old female admitted to the agency on 2/08/11 for care related to diabetes, skin breakdown, and morbid obesity. She was discharged from services on 3/15/11. Her "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 2/08/11 through 4/08/11, contained physician orders for SN services 3 times a week. The DON was interviewed on 8/25/11 at 3:30 PM. She stated it was the agency's practice, and policy, for the RN to either accompany the LPN on a visit or go instead of the LPN to evaluate nursing services provided. She stated this was occurring on a monthly basis. She stated she was not aware of the state licensing requirements of reviewing the plan of care and LPN nursing services every two weeks. She confirmed that	G 118	**When will the corrective action be implemented?** Date of Compliance: 09/19/2011. **What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action?** The DCS or designee will audit 100 % of active patient records receiving LPN or PTA services monthly for compliance with supervision. Once compliance is 98% or above for 2 consecutive months then the DCS or designee will audit at least 10% of the monthly census to ensure supervision is completed and compliant. Trends of problems identified will be reported to the PI committee. Quarterly clinical record review will include evaluating whether supervision is completed every 2 weeks for LPN and every 5th visit for PTA. The PI committee will review audits and quarterly clinical record review and develop action plans until identified problems are resolved	

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G 118	Continued From page 5 Patient #11's medical record did not contain documentation of an RN review of the POC and LPN nursing services every two weeks. LPN supervision was not conducted and documented in accordance with state licensing rules. 2. According to 24.13.01.016.02.c of the "Rules Governing the Physical Therapy Licensure Board," a patient re-evaluation must be performed and documented by the supervising PT a minimum of every five (5) visits or once a week if treatment is performed more than once per day. Patient #2 was not re-evaluated by the PT according to the licensing requirement. Patient #2 was an 83 year old male living in an ALF who was admitted to the agency on 4/14/11 for care primarily related to difficulty walking. There were six consecutive PTA visits before a re-evaluation by the supervising PT was completed, as follows: > PT visit on 4/14/11 at 1:00 PM > PTA visit on 4/19/11 at 11:08 AM > PTA visit on 4/21/11 at 1:11 PM > PTA visit on 4/26/11 at 10:59 AM > PTA visit on 4/28/11 at 2:54 PM > PTA visit on 5/03/11 at 2:13 PM > PT visit on 5/10/11 at 9:45 AM The DON was interviewed on 8/25/11 at 2:50 PM. She reviewed Patient #2's record and confirmed the delay in PT supervision of PTA visits.	G 118		

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G 118	Continued From page 6 The agency failed to ensure PT supervision of PTAs was in accordance with state licensing rules for PTs.	G 118		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on observation, review of medical records and agency policies, and staff interview it was determined the agency failed to ensure staff complied with accepted standards of practice related to infection control and injection site management. This impacted 3 of 6 sample patients (#3, #5, and #6) whose home visits were observed. These failures had the potential to introduce or facilitate the spread of an infection and increase injection site reactions. Findings include: 1. Patient #3 was a 91 year old female admitted on 8/03/11 for care of a pressure ulcer on her left foot. Her dressing change was observed on 8/23/11 from 10:20 AM to 10:45 AM. Patient #3 resided in an ALF and shared a room with another resident. The following infection control breeches were noted during the observation: a. The RN removed Patient #3's dressing, walked across the room, and placed it directly in the trash can. There was a small amount of tan drainage on the dressing and the dressing was not contained properly prior to being placed in the	G 121	**CMS STD:** G121 **CMS CFR:** 484.12(c) **Evidence:** The organization failed to demonstrate compliance with Infection Control practices and injection site management. **Agency response: What action will we take to correct the deficiency cited?** • The RN for Patient #3 was counseled on 09/06/2011 regarding infection control, appropriate disposal of soiled dressings, cleaning equipment procedure and the proper procedure for wound cleaning and dressing changes. • The PTA for Patient #5 was counseled on 09/06/2011 regarding infection control and equipment cleaning procedure. • An Infection Control and Equipment Cleaning in-service training session was completed for all direct care employees on 09/06/2011. (Copy of attendance and agenda available on site) • All direct care employees were evaluated for competency on infection control, and equipment cleaning. (Copy of competencies available on site)	

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G 121	Continued From page 7 garbage. In an environment where the garbage can was accessible to multiple residents of the ALF (some of whom were confused and disoriented) and ALF staff, there was an increased risk of exposure to potentially contaminated medical waste. The RN who provided care to Patient #3 was interviewed on 8/26/11 at 12:00 PM. She stated that best practice and agency policy required a dressing with drainage to be double bagged and placed in a garbage can with a lid. She stated if the dressing had blood or more than a small amount of drainage it was placed in a biohazard bag. She confirmed that she did not dispose of Patient #3's dressing in an appropriate manner. b. Once the dressing was removed, the RN then irrigated the wound with normal saline. The foot was observed by the surveyor to have black fuzz stuck to the outline where the tape from the dressing had been removed, between toes, and in the creases beneath her toes. The surveyor asked the RN how the dressing was managed during Patient #3's bath. The RN explained that ALF staff covered the entire foot during the bath and the foot was washed during the dressing change. The RN proceeded to cleanse the whole foot with foot peri-wound cleanser and dry the foot. She was not observed to wash or dry the foot from the cleanest area of the foot (near the wound bed) to the dirtiest (the remainder of the foot) in order to minimize potential contamination of the wound. The RN who provided care for Patient #3 was interviewed on 8/26/11 at 12:00 PM. She stated she was nervous during the observed visit and	G 121	**Who is responsible to implement the corrective action?** The Director of Clinical Services is responsible to ensure compliance. **When will the corrective action be implemented?** Date of Compliance: 09/19/2011. **What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action?** Employees for Patient #3, and #5 will be observed performing home visits periodically until satisfactory technique is demonstrated. Compliance will be monitored by the Director of Clinical Services or designee on random observation visits for all direct care employees. The Director of Clinical Services or designee will audit the Infection Control Log quarterly for trends in regards to patient infections and direct care. Trends of problems identified will be reported to the QI committee. The QI committee will review audits and develop action plans until identified problems are resolved	

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G 121	Continued From page 8 reversed her process for washing Patient #3's foot and changing the dressing. She stated the best practice standard and her usual process was to wash the foot with peri-wound cleanser then remove the dressing and wash the wound. c. Once the dressing change was finished, the RN completed a physical assessment including taking Patient #3's blood pressure, oxygen saturation level, pulse and respiration rates, and listening to her heart, lungs, and stomach with a stethoscope. The RN was observed to wipe down the equipment used in the assessment, except the stethoscope. Not properly cleaning equipment between patient use had the potential to spread infection. The RN who provided care for Patient #3 was interviewed on 8/26/11 at 12:00 PM. She confirmed the agency policy and best practice was to wipe down all equipment (including the stethoscope) with alcohol wipes. She stated she realized after the visit she failed to wipe down her stethoscope when she wiped down the rest of the equipment. Agency staff did not adhere to accepted standard of practice related to infection control. 2. Patient #6 was a 78 year old male admitted to the agency on 5/05/11 for assistance with administration of a daily insulin injection given at 1:00 PM. Nursing visit notes were reviewed from 7/04/11 through 8/18/11. During this time frame, injection sites were documented in the same location as follows: - Left arm on 7/04/11 and 7/05/11	G 121		

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G 121	Continued From page 9 - Left arm 7/08/11 through 7/10/11 - Right arm 7/19/11 through 7/21/11 - Right arm 7/26/11 and 7/27/11 - Left arm 7/28/11 and 7/29/11 - Abdomen 8/02/11 and 8/03/11 - Left arm 8/07/11 through 8/09/11 - Abdomen 8/12/11 through 8/15/11 According to the article "Good Insulin Injection Practices," dated 12/18/09 and located at www.diabeteshealth.com, "Site rotation is important to prevent scar tissue, hard lumps, or fat deposits that may develop over time." An LPN visit with Patient #6 was observed on 8/23/11 from 1:05 PM to 1:25 PM. She was observed to inject the insulin into his left arm. The LPN was interviewed via phone on 8/26/11 at 2:35 PM. She stated she had documented the injection site in the binder left in Patient #6's home. She stated she referred to the binder in order to avoid injecting in the same location two days in a row. Patient #6's RN Case Manager was interviewed on 8/26/11 at 12:00 PM. She confirmed it was best practice to rotate injections sites daily and verified in the above instances the sites were not rotated properly. She stated the agency expectation was to document the injection site in the binder which remained in the patient's home. The binder was referred to in order to avoid injecting in the same location more than one day in a row. She stated nursing staff caring for Patient #6 had difficulty meeting this expectation. A plan to ensure rotation of injection sites was not followed for Patient #6.	G 121		

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G 121	Continued From page 10 3. Patient #5 was a 79 year old female who was admitted to the agency on 8/03/11 for care related to a painful foot condition. A home visit was conducted on 8/26/11 between 9:40 AM and 10:25 AM. During the home visit, the PTA was observed to use the following equipment with Patient #5: a blood pressure cuff, stethoscope, tool to take oxygen saturation measurements, a portable bicycle, ankle weights, and arm bands. None of the equipment was observed to be cleaned/disinfected before or after use. The DON was interviewed by telephone on 8/29/11 at 12:45 PM. When asked about the agency's expectation of cleaning equipment before or after use in the home, she stated it was the expectation that equipment was cleaned with alcohol wipes after use. The agency did not ensure the PTA used infection control measures per agency expectation.	G 121		
G 122	484.14 ORGANIZATION, SERVICES & ADMINISTRATION This CONDITION is not met as evidenced by: Based on review of the HHA organization chart, agency contracts and medical records, observation, and interview it was determined the agency failed to ensure administrative control and lines of authority were clear related to contract	G 122		

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G 122	Continued From page 11 services and that patient care was adequately coordinated and documented. These failures had the potential to interfere with the quality and coordination of patient care. Findings include: 1. Refer to G123 as it relates to the agency's failure to ensure administrative control and lines of authority were clearly written and readily identifiable for contract therapy staff. 2. Refer to G142 as it relates to the agency's failure to ensure the contract utilized for therapy services contained all of the necessary requirements related to the manner in which the agency would maintain oversight of therapy services. 3. Refer to G143 as it relates to the agency's failure to ensure personnel furnishing services maintained liaison to ensure their efforts were coordinated effectively. 4. Refer to G144 as it relates to the agency's failure to ensure coordination of patient care was clearly documented in clinical records or minutes of case conferences. These cumulative negative practices impaired the HHA's organizational functioning and had the potential to negatively impact quality, coordination, and safety of patient care.	G 122		
G 123	484.14 ORGANIZATION, SERVICES & ADMINISTRATION Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily	G 123	**CMS STD:** G123 **CMS CFR:** 484.14 **Evidence:** The organization failed to demonstrate administrative control and clearly written and readily identifiable lines of authority for contracted services employed by the agency.	

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G 123	Continued From page 12 identifiable. This STANDARD is not met as evidenced by: Based on review of the HHA organization chart and staff interview, it was determined the agency failed to ensure administrative control and lines of authority were clearly written and readily identifiable for the contracted services employed by the agency. This directly impacted 9 of 12 sample patients (#1, #2, #4, #5, #7, #8, #9, #10, and #12), as well as all agency patients who received therapy services. Failure to ensure adequate oversight had the potential to impact the quality of care provided to patients. Findings include: The medical records for Patients #1, #2, #4, #5, #7, #8, #9, #10, and #12 were reviewed. Each Patient's POC contained physician orders for therapy services. The organizational chart had lines of authority delegated from the Administrator (who was named) down to the Director of Clinical Services (the DON, who was also named). In addition, a line of authority was delegated from the Administrator down to a position titled "Contracted Services" (no name listed). A line of authority was delegated from this position down to all contracted therapy services. Based on this organizational chart, it appeared therapy contractors ultimately reported to the Administrator. The Administrator was interviewed on 8/26/11 at	G 123	**Agency response: What action will we take to correct the deficiency cited?** • The organizational chart was amended on 09/19/2011 to clearly delineate a Therapy Supervisor (J.W.) to oversee contracted therapy services. The organizational chart and lines of authority were reviewed by the PAC and recommendations made to the Governing Body and key administrative staff regarding its implementation. • The newly appointed Therapy supervisor will be oriented to his job duties and responsibilities by 09/30/2011. (Copy of orientation available on site) • An in-service training session will be completed by 09/30/2011 for all contracted therapists. The contracted therapist were educated on: • Changes in organizational chart and lines of authority. • Agency's policy on Contracted Services • Introduction of the new Therapy Supervisor and his role • Supervision and Coordination of Care between agency and contracted therapists. (Copy of attendance and agenda available on site) **Who is responsible to implement the corrective action?** The Administrator and DCS is responsible to ensure compliance.	

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G 123	Continued From page 13 9:40 AM. She confirmed all therapy services (physical therapy, occupational therapy, speech therapy, and dietary consulting) were provided through contracted employees. She stated some of the therapists were independently contracted with the HHA, others were employed by an agency which was contracted by the HHA. She stated the HHA no longer had an employee in the "Contracted Services" position. She stated that Physical Therapist A "kind of" managed the therapy services, somewhat like a liaison between management and the therapy services. She stated he represented the contracted services during various meetings, including management meetings such as the Professional Advisory Committee. The Administrator stated ultimately the DON was responsible for overseeing the quality and delivery of therapy services and confirmed the organizational chart did not accurately reflect this. The DON was interviewed on 8/26/11 at 10:00 AM. She stated she believed therapy services ultimately reported to her. When asked how she ensured control over the quality and care provided by the contracted services, she reported the therapists did record review of other therapist's documentation for appropriate care documentation. She stated that through quality measures, the agency kept track of schedules for the contracted staff to ensure visits were completed as ordered. She stated she had relationships with each ALF and routinely checked with ALF staff regarding HHA staff performances. She stated once a year she went on a visit with nursing/aide staff. She stated there had not been issues identified with therapy services and therefore, she had not done (or	G 123	**When will the corrective action be implemented?** Date of Compliance: 09/30/2011. **What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action?** Compliance will be monitored by the Director of Clinical Services and Therapy Supervisor with random observation visits for contracted therapy employees. The DCS and Therapy Supervisor will continue to meet weekly with contracted therapy staff to coordinate care between and patients. The Director of Clinical Services or Therapy Supervisor will audit 100 % of active patient records receiving therapy services monthly for compliance with coordination of care. Once compliance is 98% or above for 2 consecutive months then the DCS or designee will audit at least 10% of the monthly census to ensure coordination of care documented and compliant. Trends of problems identified will be reported to the PI committee. Quarterly clinical record review will include evaluating whether coordination of care is documented on therapy patients. The PI committee will review audits and quarterly clinical record reviews and develop action plans until identified problems are resolved	

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G 123	Continued From page 14 required) oversight visits with therapists/PTAs. She stated if an oversight visit were necessary, she would request Physical Therapist A complete the visit. During a second interview on 8/29/11 at 12:15 AM, the DON stated PTs accompany PTAs on one visit a year for oversight of care. Physical Therapist B was interviewed on 8/26/11 at 10:20 AM. When asked about how the HHA provided oversight to therapy services, he referred to the expectation that his staff follow state guidelines and HHA policy. He stated the HHA policies were reviewed with him upon hire and he reviewed them with his staff at their monthly meetings. Physical Therapist A was interviewed on 8/26/11 at 11:30 AM. He stated he did not feel there was a real need for someone to fill the role of managing therapy services. He stated that because of his extensive experience as a PT in the home health field, he was often consulted by other agency staff if questions or concerns arose. He stated he did not feel he "represented" contracted services at meetings nor truly acted as a liaison for all therapy services. He stated he felt he acted more as a "sounding board" and that the DON was ultimately responsible for oversight of the contract services. Clear lines of authority and organizational control were not delineated in writing for contracted therapy services.	G 123		
G 142	484.14(f) PERSONNEL HOURLY/PER VISIT CONTRACT	G 142	**CMS STD:** G142 **CMS CFR:** 484.14 (f) **Evidence:** The organization failed to ensure the contracts utilized for therapy and dietary services clearly indicated the manner in which services would be monitored and staff expectations.	

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G 142	Continued From page 15 If personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following: (1) Patients are accepted for care only by the primary HHA. (2) The services to be furnished. (3) The necessity to conform to all applicable agency policies, including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary HHA. (6) The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation. (7) The procedures for payment for services furnished under the contract. This STANDARD is not met as evidenced by: Based on review of an agency contract and staff interview, it was determined the agency failed to ensure the contract utilized for therapy and dietary services clearly indicated the manner in which services would be monitored and staff expectations. This had the potential to negatively impact all patient who received therapy services or dietary consults from the HHA. Failure to clearly outline supervision and expectations had the potential to impact the quality and coordination of patient care and services. Findings include: 1. A sample contract used by the agency was	G 142	**Agency response: What action will we take to correct the deficiency cited?** • A new contract for therapy services was implemented on 09/19/2011. The new contract was obtained from a commercially published manual and it has been reviewed and signed by the organization and all contracted therapy agencies/staff on 09/19/2011. (Copy of new contract available on site) • The new contract includes: 1. Patients are accepted for care only by the primary HHA. 2. The services to be furnished. 3. The necessity to conform to all applicable agency policies including personnel qualifications. 4. The responsibility for participating in developing plans of care. 5. The manner in which services will be controlled, coordinated and evaluated by the primary HHA. 6. The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation. 7. The procedure for payment for services furnished under the contract. • The Therapy Supervisor has been in-serviced on or by 09/30/2011 regarding the new contract and the required elements for compliance. **Who is responsible to implement the corrective action?** The Administrator and DCS is responsible to ensure compliance.	

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G 142	Continued From page 16 reviewed and the following concerns were identified: a. The contract did not indicate how contracted personnel were oriented to HHA objectives, policies, and procedures. b. The contract did not clearly indicate the manner in which services were monitored by the HHA to ensure care was provided in accordance with POCs and that services met the terms of the contract. c. The contract did not indicate the role of contract therapists in the recertification assessments of patients for continued HHA services. The contract did not outline the manner in which documentation was reviewed to determine if the continued care was a medical necessity. d. The contract did not clearly outline the process by which contracted services were to obtain orders for therapy-specific POCs. According to the contract, "Suggestions or changes in the Plan of Care will be discussed with the Agency professional staff, which will consult with the client's physician and client/family after initial and periodic evaluations." Based on this information, it appeared contracted therapists communicated suggestions or changes in the POC to HHA staff, who in turn contacted the physician for approval. e. The contract did not indicate the procedures for scheduling visits or periodic patient evaluation. A review of the list of employees confirmed the HHA had 7 independently contracted employees	G 142	**When will the corrective action be implemented?** Date of Compliance: 09/30/2011. **What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action?** The Administrator will review the contract annually with the contracting therapies and dietary to discuss any changes or adjustments.	

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G 142	Continued From page 17 and 2 contracts with agencies who employed additional therapists. The Administrator was interviewed on 8/26/11 at 9:40 AM. She confirmed all therapy services (physical therapy, occupational therapy, speech therapy, and dietary consulting) were provided through contracted employees. She stated some of the therapists were independently contracted with the HHA, others were employed by an agency that was contracted by the HHA. The Administrator confirmed that all contracts were the same format as the one reviewed. She stated the HHA had requested the contracts be reviewed by an attorney to be more thoroughly and accurately developed and confirmed some required pieces were not complete or clear. The Administrator clarified that physical, occupational, and speech therapists were expected to contact the physician directly to obtain verbal orders for the POC they developed. She stated it was not the HHA's expectation that only directly employed staff would contact families and physicians regarding the POC. Contractual agreements utilized by the HHA were not clear and complete.	G 142		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on observation, record review, and staff	G 143	**CMS STD:** G143 **CMS CFR:** 484.14 (g) **Evidence:** The organization failed to demonstrate personnel furnishing services maintained liaison to ensure their efforts were coordinated effectively for patients.	

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G 143	Continued From page 18 interview it was determined the agency failed to ensure personnel furnishing services maintained liaison to ensure their efforts were coordinated effectively for 1 of 6 patients (#5) who were observed in their places of residence. This had the potential to result in unmet patient needs. Findings include: Patient #5 was a 79 year old female who was admitted to the agency on 8/03/11 for care related to a painful foot condition. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 8/03/11 to 10/01/11, included orders for physical therapy services. A home visit with Patient #5 and a PTA was conducted on 8/26/11 between 9:40 AM and 10:25 AM. During the home visit, surveyors observed Patient #5 report to the PTA she had severe itching around her neck and a feeling like she was breaking out. The PTA was observed to look at Patient #5's neck and to tell Patient #5 she would report the symptoms to ALF staff after the visit. The PTA left the visit without being observed to report symptoms to ALF staff. Surveyors reported the symptoms to the ALF Administrator at 10:25 AM immediately after the visit. The ALF Administrator responded by saying Patient #5 was in the ED the day before because of chest pain. During the ED visit, Patient #5's itching was addressed and she was put on Benadryl 4 times per day. She also stated the ED found Patient #5's chest pain symptoms were related to anxiety. During the home visit, the PTA was observed to	G 143	**Agency response: What action will we take to correct the deficiency cited?** • The PTA for Patient #5 was counseled on 09/06/2011regarding reporting Emergency Department visits and reporting changes in patients' condition immediately to ALF and PT. • An In-service training session for all direct care staff was completed on 09/06/2011. (Copy of attendance and agenda available on site) The in-service training session included: • Notifying supervisors of changes in patient conditions and Emergency Department visits immediately • Notifying ALF of changes in patient conditions • Documenting notification to supervisor on progress note or a communication note. **Who is responsible to implement the corrective action?** The Director of Clinical Services is responsible to ensure compliance. **When will the corrective action be implemented?** Date of Compliance: 09/30/2011.	

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G 143	Continued From page 19 contact the supervising PT by telephone and give a report of the summary of the visit. There was no mention of the ED visit the day prior or Patient #5's report of neck itching or new medications. The PTA's visit note, dated 8/25/11 at 9:50 AM for the observed visit, did not reference the itching on Patient #5's neck, the telephone call to the PT, or any communication with the ALF regarding the ED visit or a new medication. During an interview with Physical Therapist B on 8/26/11 at 10:10 AM, he was asked what he would do if he were notified a patient had an ED visit. He stated if he knew of an ED visit, he would attempt to get a copy of the ED report and review it. He explained changes in a patient's condition could require an update to the POC. The agency did not ensure the PTA maintained liaison with the ALF and supervising PT to communicate relevant information in a timely manner.	G 143	**What is the monitoring process we will pnt into place to ensure implementation and effeetiveness of the eorrective action?** The DCS or designee will audit the records of 100 % of the census until compliance is evident, and then 10% of the monthly census to ensure coordination of care is completed and documented. Trends of problems identified will be reported to the PI committee. Quarterly clinical record review will include evaluating the timeliness of coordination of care, coordination between all disciplines involved and whether coordination of care is documented. The PI committee will review audits and quarterly clinical record review and develop action plans until identified problems are resolved	
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 coordination of patient care was clearly documented in clinical records or minutes of case	G 144	**CMS STD:** G144 **CMS CFR:** 484.14 (g) **Evidence:** The organization failed to demonstrate coordination of care was clearly documented in clinical records or minutes of case conferences. **Agency response: What action will we take to correct the deficiency cited?** • The PTAs and PTs for Patient #1 and #10 were counseled on 09/06/2011 regarding documenting coordination of care between PT and PTA, patient, family and ALF.	

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G 144	Continued From page 20 conferences for 6 of 12 patients (#1, #2, #4, #6, #7, and #10) whose records were reviewed. This had the potential to interfere with quality, coordination, and continuity of patient care. Findings include: 1. Patient #10 was a 93 year old female living in an ALF who was admitted to the agency on 3/24/11 for care primarily related to a superficial infection of her forearm from a dog bite. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 3/24/11 to 5/22/11, included a diagnosis of senile dementia and orders for physical therapy services. The following PTA visit notes documented Patient #10's resistance to physical therapy. They did not document any coordination of care with the PT, Case Manager, family, or ALF staff. > PTA visit note, dated 3/31/11 at 11:47 AM, documented Patient #10 repetitively asked why physical therapy was there to see her, saying she did not invite PTA to see her. > PTA visit note, dated 4/05/11 at 9:37 AM, documented Patient #10 repetitively asked why the PTA was there to see her. > PTA visit note, dated 4/14/11 at 11:30 AM, documented Patient #10 repetitively asked the PTA who sent her. It also stated Patient #10 refused to ambulate during the visit. > PTA visit note, dated 4/28/11 at 10:32 AM, documented Patient #10 asked why the PTA was there to see her. It stated Patient #10 refused repetitively to transfer and ambulate.	G 144	• The PTA for Patient #4 was counseled on 09/06/2011 regarding notifying PT immediately of changes in patients' conditions and notifying the physician or PT if blood glucose is above or below written parameters. • The PT for Patient #4 was counseled on 09/06/2011 regarding documenting changes in the patient's plan of care and instructing PTA of changes. • The PTA and the PT for Patient #2, #7 were counseled on 09/06/2011 regarding documenting coordination of care and notification of changes in the patient's condition. • An in-service training session on Diabetes Management and Reporting changes to Physicians was completed on 09/06/2011 for all nursing staff (LPNs and RNs). (Copy of attendance and agenda available on site) The In-service training session consisted of: • Documenting notification from ALF regarding blood glucose levels that are above or below parameters. • Notifying the physician of patient's whose blood glucose levels that are above or below parameters and documenting notification. • Documenting interventions provided from ALF or SN when a patient's blood glucose level was above or below parameters. • Documenting coordination of care between ALF and home health staff.	

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G 144	Continued From page 21 > PT visit note, dated 5/12/11 at 10:25 AM, documented Patient #10 refused any participation in physical therapy. She was then discharged from physical therapy. Physical Therapist B was interviewed on 8/26/11 at 11:00 AM. When asked if the PTA had let him know, as the supervising therapist, about the findings in the above-referenced visits, he stated the PTA called after every visit. When asked why physical therapy services were continued despite Patient #10's apparent resistance, he confirmed Patient #10's resistance. He stated he, as the supervising PT, had been in constant contact with the ALF administrator from the beginning of Patient #10's care. He stated Patient #10 was very responsive to the administrator and was in constant contact with Patient #10's family who wanted physical therapy continued. He stated he did not document the coordination of care, but it did take place. He explained physical therapy staff did not coerce Patient #10 but adapted their work each visit around Patient #10's willingness. When Patient #10 was no longer willing to participate at all in physical therapy, they discharged her. The agency did not ensure documentation of coordination of care between the PTA and PT or between the PT and administration/family in the clinical record or in case conference notes. 2. Patient #4 was a 59 year old male who was admitted to the agency on 4/01/11 for care primarily related to back pain. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification periods 5/31/11 to	G 144	**Who is responsible to implement the corrective action?** The Director of Clinical Services is responsible to ensure compliance. **When will the corrective action be implemented?** Date of Compliance: 09/19/2011. **What is the monitoring process we will put into place to ensure implementation and effectiveness of the correetive action?** The DCS or designee will audit the records of 100 % of the census until compliance is evident, and then 10% of the monthly census to ensure coordination of care is completed and documented and notification to physician is completed and documented. Trends of problems identified will be reported to the PI committee. Quarterly clinical record review will include evaluating the timeliness of coordination of care, coordination between all disciplines involved and whether coordination of care is documented. The PI committee will review audits and quarterly clinical record review and develop action plans until identified problems are resolved	

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G 144	Continued From page 22 7/29/11, included orders for physical therapy services. PTA visit notes (referenced below) documented changes in patient status that would have merited communication with the supervising PT. However, there was no documentation of communication between the PTA and PT related to patient conditions. > A PTA visit note, dated 6/06/11 at 2:00 PM, documented Patient #4 complained of not feeling well during the visit and was unable to ambulate during the visit because of high blood pressure from weekend activities. > A PTA visit note, dated 6/24/11 at 1:30 PM, referenced a new POC. However, there was no documentation of a new POC. > A PTA visit note, dated 7/01/11 at 3:20 PM, reported an elevated blood glucose level of 190 mg/dl and an inability of Patient #4 to ambulate without an assistive device. An agency protocol, adopted by the governing body in April of 2010, required physician notification for blood sugar levels outside of the range 60-200 mg/dl. Although 190 mg/dl was not within the range to report to the physician, it was sufficiently elevated to report to the supervising PT. > A PTA visit note, dated 7/18/11 at 2:10 PM, documented an elevated blood glucose level of 220 mg/dl. Agency protocol required reporting a blood glucose level >200 mg/dl to the physician. > A PTA visit note, dated 7/21/11 at 3:31 PM, documented an elevated blood glucose of 200	G 144		

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G 144	Continued From page 23 mg/dl. > A PTA visit note, dated 7/25/11 at 4:05 PM, documented a decreased heart rate of 49 beats per minute. An agency protocol, adopted by the governing body in April of 2010, required physician notification for heart rates below 60 beats per minute. Physical Therapist B, the PT supervisor for Patient #4, was interviewed on 8/26/11 at 10:50 AM. He reviewed Patient #4's record and confirmed visit notes (referenced above) did not document communication between the PTA and PT. However, he stated the PTAs communicated regularly with him related to Patient #4 and it was likely the information had been reported. He stated in reference to the "new POC" mentioned in PTA visit note on 6/24/11, there was not actually a new POC, probably just new home exercises. When asked what he would have done with the information related to the elevated blood glucose and the decreased heart rate, he stated he would have reported the information either directly to the doctor or the RN Case Manager or to the DON. He confirmed there was no documentation the information had been reported to any of the above. The agency did not ensure the clinical record documented reporting and coordination of patient care. 3. Patient #2 was an 83 year old male living in an ALF who was admitted to the agency on 4/14/11 for care primarily related to difficulty walking. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 4/14/11 to	G 144		

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G 144	Continued From page 24 6/12/11, included orders for physical therapy 2 times per week for 6 weeks. The following PTA visit notes documented reports of patient falls. There was no documentation of communication from the PTA to the PT regarding the findings. > PTA visit note, dated 4/19/11 at 11:08 AM, documented ALF staff reported Patient #2 fell on 4/17/11 without serious injury. > PTA visit note, dated 4/21/11 at 1:11 PM, documented ALF staff reported a second fall without serious injury. The date of the fall was not documented. > PTA visit note, dated 5/05/11 at 9:45 AM, documented ALF staff reported Patient #2 fell the night before and went to the ED for evaluation. Physical Therapist B was interviewed on 8/26/11 at 10:45 AM. He stated the PTA did report the falls to him. He confirmed there was no documentation of the reporting. He further stated the ALF transferred Patient #2 to a skilled nursing facility on 5/12/11 because of the frequency of falls. The agency did not ensure the PTA documented reports of Patient #2's falls to the PT. 4. Patient #7 was a 79 year old male who was admitted to the agency on 5/23/11 for care related to difficulty walking and an abnormal brain condition (called normal pressure hydrocephalus). The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for	G 144		

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G 144	Continued From page 25 certification period 5/23/11 to 7/21/11, included orders for physical therapy evaluation to develop a home exercise program. A PTA visit note, dated 6/29/11 at 9:04 AM, documented Patient #7 reported falling the night before without serious injury. There was no documentation the fall had been reported to the supervising PT. Physical Therapist B was interviewed on 8/26/11 at 11:10 AM. He stated the PTA did report the fall but did not document the coordination. He explained there was a lot of verbal communication that did not get documented. The agency did not ensure the PTA documented a report to the PT about Patient #7 falling. 5. Patient #6 was a 78 year old male admitted to the agency on 5/05/11 for assistance with administration of a daily insulin injection to be given at 1:00 PM. Patient #6 resided in an ALF and staff at the ALF were responsible for checking his blood glucose levels. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 7/04/11 through 9/01/11, contained SN goals related to Patient #6's care. One goal was for Patient #6's fasting blood glucose level to remain between 60 mg/dl and 200 mg/dl, and that ALF staff were to report abnormal lab values. During an interview on 8/22/11 at 2:05 PM, the DON stated the agency had protocols in place regarding when to report abnormal vital signs and blood sugar levels (unless otherwise specified by the physician). She presented the protocol	G 144		

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G 144	Continued From page 26 adopted by the governing body in April of 2010. According to the protocol, blood sugar levels outside of the range 60-200 mg/dl were to be reported to the physician. In addition, Patient #6's medical record contained a "PHYSICIAN ORDER CONFIRMATION" form, dated 7/21/11, and signed by the physician. The physician requested to be notified of fasting blood glucose levels over 400 mg/dl and less than 60 mg/dl. "SKILLED NURSING VISIT NOTES" for visits between 7/04/11 and 8/18/11 were reviewed. ALF staff checked Patient #6's fasting blood glucose level at 8:00 AM each morning. Home health nursing staff documented this fasting blood glucose level on their visit notes. On the following dates, nursing staff documented blood glucose levels less than 60 mg/dl: - The LPN documented a blood glucose of 55 mg/dl on 7/05/11. - The LPN documented a blood glucose of 55 mg/dl on 7/06/11. - The LPN documented a blood glucose of 52 mg/dl on 7/19/11. - The LPN documented a blood glucose of 48 mg/dl on 7/20/11. - The RN documented a blood glucose of 56 mg/dl on 8/01/11. - The RN documented a blood glucose of 58 mg/dl on 8/07/11. - The RN documented a blood glucose level of 58 mg/dl on 8/09/11. The medical record did not contain documentation HHA nursing staff were notified of	G 144		

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G 144	Continued From page 27 the low blood glucose levels prior to the visit around 1:00 PM. The medical record did not contain documentation that the physician was notified of the low blood glucose levels, or what interventions were provided in response to the low levels. The RN Case Manager for Patient #6 was interviewed on 8/26/11 at 12:00 PM. She reviewed Patient #6's medical record and stated the ALF staff had reported the blood glucose levels below 60 mg/dl. She stated typically the ALF staff called the agency after they gave Patient #6 some orange juice and rechecked his blood glucose level. The Case Manager stated by the time the agency got the report from the ALF, the blood glucose level was back within normal limits. She stated once a low blood glucose level was reported to the agency from ALF staff, the agency would fax the physician a notification. She confirmed there was no documentation to reflect the coordination of care between ALF and home health staff, or home health staff and the physician. The medical record did not contain documentation of effective reporting, interchange, and coordination of patient care. 6. Patient #1 was an 80 year old female admitted to the agency on 4/11/11 for therapy services to improve ambulation. She was discharged from the agency on 8/08/11. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification periods 4/11/11 through 6/09/11 and 6/10/11 through 8/08/11, contained orders for physical therapy 2 times a week throughout the certification period.	G 144		

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G 144	Continued From page 28 The medical record did not contain documentation of coordination of care between the PT and the PTA (who worked for Physical Therapist B) who were providing services to Patient #1. Physical Therapist B was interviewed on 8/26/11 at 10:20 AM. He stated the physical therapists and PTAs who work for him talk with each other on a daily basis regarding the status and progress of their patients. The DON reviewed Patient #1's medical record on 8/25/11 at 4:45 PM. She confirmed there was no documentation present in the record to indicate coordination of care between the PT and the PTA had occurred. The medical record did not contain documentation of effective interchange, reporting, and coordination of patient care.	G 144		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure care was provided in accordance with the established plan of care for 6 of 12 (#4, #7, #8, #9, #10, and #12) whose records were reviewed. This resulted in missed or delayed visits and had the potential to interfere with patient progress towards	G 158	**CMS STD:** G158 **CMS CFR:** 484.18 **Evidence:** The organization failed to demonstrate care was provided in accordance with the established plan of care. **Agency response: What action will we take to correct the deficiency cited?** • The MSW for Patient #9 was counseled on 09/06/2011 regarding the agency policy for completing an evaluation upon receipt of an order, documentation of delays in an evaluation and notification to physician of the delay.	

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G 158	Continued From page 29 reaching goals. Findings include. 1. Patient #9 was a 93 year old male admitted to the agency on 8/03/11 for evaluation and care related to generalized weakness and dementia. Patient #9's medical record contained a "PHYSICIAN ORDER CONFIRMATION," signed by the primary care provider on 8/05/11, authorizing a social work evaluation. His "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 8/03/11 through 10/01/11, contained physician orders for SN visits 1 time a week for 1 week and then 2 times a week for 2 weeks. Physical therapy was to see him 2 times a week for 1 week and then 3 times a week for 2 weeks, then 2 times a week for 1 week. a. The medical record contained a social work evaluation completed on 8/16/11, 11 days after the referral order. During an interview on 8/22/10 at 2:05 PM, the DON explained the agency permitted a 5 day window in which evaluations were to be completed upon receipt of the order. The RN Case Manager for Patient #9 was interviewed on 8/26/11 at 1:15 PM. She reviewed the record and recalled the Social Worker had a difficult time contacting Patient #9's Durable Power of Attorney to arrange a time to conduct the evaluation. The Case Manager confirmed no explanation for the delayed visit was documented in the medical record. b. Patient #9's medical record contained documentation for one physical therapy visit	G 158	• The PT for Patient # 7 was counseled on 09/06/2011 regarding following the patient's plan of care and obtaining an order from the physician for changes in the patient's plan of care and frequency. The PT shall document changes in their visit notes and in the patient record. • The agency implemented a new process on 09/19/2011 to ensure the physician is notified of changes in the plan of care. All missed visit notes will be faxed to the patient's physician. The clerical assistant is responsible for notifying the physician and will fax a copy of the missed visit note upon receipt to the patient's physician. The fax confirmation sheet will be attached to the missed visit note to document the date and method of which the physician was notified. • The clerical assistant was counseled on 09/06/2011 regarding the correct procedure for faxing and documenting notifying the physician of a missed visit. • An In-service training session for all direct care staff on Documenting Missed Visits and Changes in the Patient's Plan of Care was completed on 09/06/2011. (Copy of attendance and agenda available on site) The In-service training session consisted of: • Documenting missed visits and a missed visit note.	

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G 158	Continued From page 30 during week 2. The record also contained "MISSED VISIT" notes completed by the PTA for visits missed during week 2. One note was dated 8/11/11 and 8/12/11, and a second note was dated 8/12/11. The PTA documented on both notes the reason for the visit was that the "Patient refused." Both notes were signed by the PTA on 8/12/11 and contained a stamp which read "M.D. NOTIFIED." There was no indication who notified the physician, how the physician was notified (via fax or phone), and no documentation of when the physician was notified of the alteration in the plan of care. c. Patient #9's medical record contained documentation of one RN visit during week 2. The record also contained a "MISSED VISIT" note, completed by the RN on 8/12/11. The RN documented the reason for the missed visit was that Patient #9 was out of the facility with his family. This note also contained the "M.D. NOTIFIED" stamp. There was no indication who notified the physician, how the physician was notified (via fax or phone), and no documentation of when the physician was notified of the alteration in the plan of care. The DON reviewed Patient #9's medical record on 8/26/11 at 1:00 PM. She confirmed the "MISSED VISIT" notes did not contain the proper documentation to adequately show who notified the physician, how the physician was notified, and when the physician was notified of the missed visits. Services were not provided in accordance to the established POC.	G 158	• The staff was instructed to try and reschedule the visit for another day or time during the same week and if unable then to notifying their supervisor or the DCS of the missed visit and document the missed visit on a missed visit note. • Missed visits notes are to be turned in immediately. • When changes are needed in the patient's plan of care the physician must be notified and an order must be obtained. **Who is responsible to implement the corrective action?** The Director of Clinical Services is responsible to ensure compliance. **When will the corrective action be implemented?** Date of Compliance: 09/19/2011. **What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action?** The DCS or designee will audit 100% of the Missed Visit Notes and initial therapy evaluations to ensure compliance. Once a 98% compliance rate has been met for 1 month then the DCS or designee will audit 10% of the Missed Visit Notes and initial therapy evaluations monthly to ensure physician notification of changes in plan of care is completed and documented. Trends of problems identified will be reported to the PI committee.	

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G 158	Continued From page 31 2. Patient #4 was a 59 year old male who was admitted to the agency on 4/01/11 for care primarily related to back pain. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification periods 5/31/11 to 7/29/11, included orders for physical therapy 2 times per week for 9 weeks. During the third week (beginning 6/12/11), there was documentation of one missed visit (6/17/11) and notification to the doctor. There was no documentation of a second visit according to the POC or a second missed visit with physician notification. During the sixth week (beginning 7/03/11), there was one PTA visit on 7/05/11. There was no documentation of a second visit according to the POC or a missed visit with physician notification. The DON was interviewed on 8/25/11 at 4:10 PM. She reviewed Patient #4's record and confirmed the missed physical therapy visits during the third and sixth week of service and lack of sufficient documentation to confirm the physician had been notified. The agency did not ensure physical therapy visits followed the written plan of care. 3. Patient #8 was an 87 year old male who was admitted to the agency on 7/20/11 for care primarily related to muscle weakness and cellulitis. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 7/20/11 to 9/17/11, included physician orders for OT services 1 time per week for the first week, followed by 2 times per week for 6 weeks.	G 158	Quarterly clinical record review will include evaluating the timeliness of initial therapy evaluations, documentation of physician notification with missed visits and coordination of care between all disciplines involved. The PI committee will review audits and quarterly clinical record review and develop action plans until identified problems are resolved	

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G 158	Continued From page 32 During the 4th week (beginning 8/07/11) there were no completed OT visits compared to the 2 visits that were ordered. There was documentation of 2 missed visits (8/09/11 and 8/11/11) during the 4th week. However, there was insufficient documentation to determine the physician had been notified of the missed visits. During the 5th week (beginning 8/14/11) there was documentation of one completed visit (8/18/11) instead of the 2 visits ordered. There was documentation of one missed visit (8/16/11). However, there was no documentation the physician had been notified of the missed visit. During an interview on 8/25/11 at 4:10 PM, the DON stated they routinely faxed missed visit notes to the physician but sometimes forgot to document having done so. The agency did not ensure occupational therapy visits followed Patient #8's written plan of care. 4. Patient #10 was a 93 year old female living in an ALF who was admitted to the agency on 3/24/11 for care primarily related to a superficial infection of her forearm from a dog bite. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 3/24/11 to 5/22/11, included orders for a physical therapy evaluation. Following the physical therapy evaluation on 3/29/11, physician orders followed for physical therapy 2 times per week for 6 weeks. During the 5th week (beginning 4/17/11), there was one visit (4/21/11) instead of the two visits	G 158		

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G 158	Continued From page 33 that were ordered. There was documentation of a missed physical therapy visit during the week but no evidence of physician notification. During the 7th week (beginning 5/01/11), there was one visit (5/05/11) instead of two visits that were ordered. There was documentation of a missed visit during the week but no evidence of physician notification. The DON was interviewed on 8/25/11 at 4:00 PM. She reviewed Patient #10's record and confirmed there was insufficient documentation to confirm the physician had been notified of the missed visits. She stated the agency routinely faxed missed visit forms to the physician but sometimes forgot to document the missed visit form had been faxed to the physician. The agency did not ensure physical therapy visits followed the written plan of care and/or ensure the physician was notified of missed visits. 5. Patient #12 was an 81 year old female who was admitted to the agency on 7/29/11 for care primarily related to joint pain. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification period 7/29/11 to 9/26/11, included orders for a PT evaluation. Following a PT evaluation on 7/29/11, physician orders followed for physical therapy visits 1 time per week for one week, followed by 2 times per week for 4 weeks. During the 3rd week (beginning 8/07/11), there was one PT visit (8/11/11) instead of the two ordered on the POC. There was documentation of a missed visit during the week (8/09/11).	G 158		

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G 158	Continued From page 34 However, there was no documentation of physician notification. During the 4th week (beginning 8/14/11) there was one PT visit (8/19/11) instead of the two visits ordered on the POC. There was documentation of a missed visit during the week (on 8/16/11). However, there was no documentation of physician notification. The DON was interviewed on 8/25/11 at 4:10 PM. She reviewed Patient #12's record and confirmed there was insufficient documentation to determine the physician had been notified of the missed visits. She explained the agency routinely faxed missed visit forms to the physicians but sometimes forgot to document having done so. The agency did not ensure physical therapy visits were provided in accordance with the POC. 6. Patient #7 was a 79 year old female who was admitted to the agency on 5/23/11 for care related to difficulty walking and an abnormal brain condition (called normal pressure hydrocephalus). The "PHYSICAL THERAPY CARE PLAN," dated 5/23/11 and signed by the physician, included a planned visit frequency of 4 times per week for the first 2 weeks. During the first week, there were 5 physical therapy visits documented rather than the 4 physical therapy visits that were ordered, including visits on 5/23/11, 5/24/11, 5/25/11, 5/26/11, and 5/27/11. The DON was interviewed on 8/25/11 at 3:40 PM. She reviewed Patient #7's record and confirmed	G 158		

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G 158	Continued From page 35 the extra physical therapy visit. The agency did not ensure physical therapy visits were provided in accordance with the POC.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on record review, staff interview, and patient interview it was determined the agency failed to ensure the plan of care included all relevant information for 4 of 12 patients (#1, #4, #6, and #7) whose records were reviewed. This had the potential to interfere with quality and coordination of patient care. Findings include: 1. Patient #4 was a 59 year old male who was admitted to the agency on 4/01/11 for care primarily related to back pain. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification periods 5/31/11 to 7/29/11 and 7/30/11 to 9/27/11, included a diagnosis of diabetes. The POC did not include his medications, insulin or Oxycodone, or the DME, a TENS unit. a. A home visit was conducted on 8/23/11	G 159	**CMS STD:** G159 **CMS CFR:** 484.18(a) **Evidence:** The organization failed to demonstrate relevant information was included in patients' plans of care. **Agency response: What action will we take to correct the deficieney cited?** • The physician for patient #4 was notified of the missing items on the plan of care and a clarification order was written to add Insulin: Lantus and Humalog sliding scale, Oxycodone and TENS unit to the recertification plan of care dated 7/30/11-9/27/11. • The physician for patient #7 was notified of the missing surgical diagnosis for the plan of care dated 7/22/11-9/19/11 and a clarification order was obtained to add Stent diagnosis to the plan of care. • The physician for patient #1 was notified of the missing items to the plan of care dated 6/10/11-8/08/11 and a clarification order was obtained to add Codeine allergy and DME supplies; wheelchair and walker to the plan of care.	

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G 159	Continued From page 36 between 2:00 PM and 3:15 PM. Patient #4 was interviewed regarding his medications. He explained he was on a sliding scale for insulin 4 times per day, Humalog before meals 3 times per day, and Lantus before bedtime. When asked how long he had been on insulin, he stated he had been on insulin since a back surgery, prior to the time the home health agency began seeing him. He also stated he took Oxycodone, up to 6 pills in a 24 hour period. He stated "I take 4 on a good day." The DON was interviewed on 8/25/11 at 4:10 PM. She reviewed Patient #4's record. She stated she was not aware Patient #4 was on insulin or on Oxycodone. She confirmed the medications were not on the POC. The RN Case Manager for Patient #4 was interviewed on 8/26/11 between 8:35 AM and 9:20 AM. She stated she was aware Patient #4 was on Lantus insulin and that it was an "oversight" that it was not placed on the POC. She stated she did not know about the Humalog insulin. She stated she was aware Patient #4 was taking Oxycodone, stating it was mixed with Amitriptiline. She described its omission from the POC as a "clerical error." b. A PTA visit note, dated 7/18/11 at 2:10 PM referenced Patient #4 using a TENS unit. This was not on the POC. Physical Therapist A was interviewed on 8/26/11 at 10:50 AM. He reviewed Patient #4's record and confirmed the TENS unit should have been included in the POC.	G 159	• The physician for patient #6 was notified of the missing items to the plan of care dated 7/04/11-9/01/11 and a clarification order was obtained to include; ALF to check patient's blood glucose two times day. Diabetic foot examinations were to be completed monthly by podiatrist who visited ALF. • The nurses and the physical therapists caring for patients #1,#4, #6 and #7 were counseled individually to apprise them of errors and state expectations for the future. • In-service education program for all direct care staff regarding the agency's policy on Plan of Care and ensuring relevant information was included in patients' plans of care was completed on 09/06/2011. (Copy of agenda and attendance on site) Staff were instructed to: • Include all pertinent diagnoses (both principle and secondary) with dates of onset to the plan of care • Include all DME used by the patient or therapist on the plan of care • Ensure all allergies and medications are listed on the plan of care • Include all treatments and interventions on the plan of care • Staff shall review each plan of care for completeness and accuracy prior to signing and prior to sending to physician for signature.	

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G 159	Continued From page 37 The agency did not ensure insulin, Oxycodone, and a TENS unit were included on Patient #4's POC. 2. Patient #7 was a 79 year old male who was admitted to the agency on 5/23/11 for care related to difficulty walking and an abnormal brain condition called normal pressure hydrocephalus. An RN's Summary Note attached to the "COMPREHENSIVE ADULT NURSING ASSESSMENT," dated 5/23/11, stated Patient #7 underwent surgery to place a shunt in the right side of his head related to the normal pressure hydrocephalus. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE, for certification period 7/22/11 to 9/19/11, did not include information related to the surgery. The DON was interviewed on 8/25/11 at 3:40 PM. She reviewed Patient #7's record and confirmed the information was missing from the POC. The agency did not ensure a relevant diagnosis was included in the POC. 3. Patient #1 was an 80 year old female admitted to the agency on 4/11/11 for therapy services to improve ambulation. She was discharged from the agency on 8/08/11. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 6/10/11 through 8/08/11, was missing the following information: a. The section related to DME and supplies indicated Patient #1 was not using additional medical equipment for her therapy. However, the	G 159	**Who is responsible to implement the corrective action?** The Director of Clinical Services is responsible to ensure compliance. **When will the corrective action be implemented?** Date of Compliance: 09/19/2011. **What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action?** The DCS or designee will audit 100% of the initial and recertification plans of care monthly to ensure completeness, accuracy and compliance. Trends of problems identified will be reported to the PI committee. Quarterly clinical record review will include evaluating Plans of Care for completeness and all pertinent information. The PI committee will review audits and quarterly clinical record reviews and develop action plans until identified problems are resolved	

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G 159	Continued From page 38 POC indicated the activities permitted for Patient #1 included being up as tolerated and using a wheelchair and a walker. In addition, one of the therapy goals for Patient #1 was to ambulate with a front wheeled walker with only stand-by assistance. b. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period of 4/11/11 through 6/09/11, indicated Patient #1 was allergic to Codeine. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification periods 6/10/11 through 8/08//11, indicated Patient #1 had no allergies. The DON reviewed Patient #1's medical record on 8/25/11 at 3:30 PM. She confirmed the DME and supplies were not listed on the POC. She confirmed the Codeine allergy should have been on the recertification POC and was not. The POC did not include the DME and supplies Patient #1 utilized and did not contain the correct information related to allergies. 4. Patient #6 was a 78 year old male admitted to the agency on 5/05/11 for assistance with administration of a daily insulin injection to be given at 1:00 PM. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 7/04/11 through 9/01/11, listed the following nursing interventions related to diabetes: medication teaching, evaluate medication effects/compliance, prepare insulin syringes, administer medication (Lantus insulin 20 units injected subcutaneously daily), and teach diabetic care. The plan of care did not address how the agency was going to monitor Patient #9's	G 159		

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G 159	Continued From page 39 blood glucose levels or who would complete his diabetic foot examinations. The RN Case Manager for Patient #6 was interviewed on 8/26/11 at 12:00 PM. She stated staff at the ALF checked Patient #6's glucose level two times a day. She stated she assessed Patient #6's feet on admit but the ALF had a podiatrist who came to the facility one time a month to perform diabetic feet examinations. She confirmed this information related to diabetes management was not on the POC. The POC did not include information related to diabetes management and assessment for Patient #6. The agency's "PLAN OF CARE" policy, undated, was reviewed. According to the policy, the POC was to contain, among other elements, all pertinent diagnoses (both principle and secondary) with dates of onset, specific procedures and modalities for therapy services, and medical supplies and equipment required. The agency did not ensure POCs included all pertinent information.	G 159		
G 185	484.32 THERAPY SERVICES Any therapy services offered by the HHA directly or under arrangement are given by a qualified therapist or by a qualified therapy assistant under the supervision of a qualified therapist and in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on observation, record review, and staff	G 185	**CMS STD:** G185 **CMS CFR:** 484.32 **Evidence:** The agency failed to demonstrate PTA services were provided in accordance with the plan of care.	

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G 185	Continued From page 40 interview it was determined the agency failed to ensure PTA services were provided in accordance with the plan of care for 1 of 1 patient (#5) observed in a home setting providing PTA services. This had the potential to negatively impact quality, continuity, and coordination of patient care. Findings include: Patient #5 was a 79 year old female who was admitted to the agency on 8/03/11 for care related to a painful foot condition. The "PHYSICAL THERAPY CARE PLAN," dated 8/03/11, included a walker as relevant equipment. There was no other relevant equipment listed on the physical therapy POC. A home visit was conducted on 8/26/11 between 9:40 AM and 10:25 AM. During the home visit, no walker was observed to be present. Instead, the followed equipment was observed to be utilized by the PTA with Patient #5: a lap belt to ambulate Patient #5, a portable exercycle, ankle weights, and arm bands. When asked about Patient #5's walker, the PTA stated Patient #5 did not have a walker but she (the PTA) had borrowed the ALF's walker for use early on after the SOC. She stated she (the PTA) thought the walker was more of a hazard than a help because Patient #5 was blind and would run into walls with the walker. She explained she saw ALF staff use a lap belt, so she decided to use the lap belt to ambulate Patient #5 and thought it would be better than using the walker. When asked how she knew to use the bicycle exercise equipment, ankle weights, and arm bands, since they were not on the POC, she stated she made the choice to use the equipment based on the PT's assessment and established goals. When asked	G 185	**Agency response: What action will we take to correct the deficiency cited?** • The PTA for Patient # 5 was counseled on 09/06/2011 regarding following the patient's plan of care and notifying PT for changes in the patient's plan of care and DME needs. The PTA shall document coordination of care and changes made by the PT on their visit note. • An In-service training session for all PTAs on following the Plan of Care was completed on 09/06/2011. (Copy of attendance and agenda available on site) The In-service training session consisted of: • Following the plan of care as assigned by the Physical Therapist. • Notify the Physical Therapist of changes in the patient's condition • Notify the Physical Therapist of any missed visits. • Documenting coordination of care and notification of changes on their progress note. **Who is responsible to implement the corrective action?** The Director of Clinical Services is responsible to ensure compliance. **When will the corrective action be implemented?** Date of Compliance: 09/19/2011. **What is the monitoring process we will put in place to ensnre implementation and effectiveness of the corrective action plan?** The Director of Clinical Services or	

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G 185	Continued From page 41 how another PTA would know to use the equipment since it was not on the POC, she stated they could read her visit notes to know. The agency did not ensure the PTA followed the physical therapy POC.	G 185	Therapy Supervisor will audit monthly 100% of the patient records receiving PTA services to ensure the PTAs follow the patient's plan of care. Trends of problems identified will be reported to the QI committee. Quarterly clinical record review will include evaluating whether the care provided follows the written plan of care. The PI committee will review audits and quarterly clinical record reviews and develop action plans until identified problems are resolved	
G 225	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the home health aide provided services in accordance with the established POC for 1 of 2 sample patients (#11) who received home health aide services. This practice had the potential to negatively impact patient care. Findings include: Patient #11 was a 74 year old female admitted to the agency on 2/08/11 for care related to diabetes, skin breakdown, and morbid obesity. She was discharged from services on 3/15/11. Her "HOME HEALTH AIDE CARE PLAN," completed by an RN on 2/08/11, indicated the home health aide was to complete visits 3 times a week. The RN included instructions for the aide to assist with hair care/shampoo and provide oral care with each visit. In addition, the aide was to assist with light housekeeping in the bedroom and bathroom on a weekly basis. The RN did not include instructions for the aide to provide foot care.	G 225	**CMS STD: G225** **CMS CFR:** 484.36 (c)(2) **Evidence:** The agency failed to demonstrate home health aides services were provided in accordance with the plan of care. **Agency response: What action will we take to correct the deficiency cited?** • The home health aide caring for the patient #11 was counseled on 09/06/2011 on following the plan of care exactly and to notify the Registered Nurse or supervisor of patient's requests or changes in the plan of care. • Home health aides and were in-serviced on 09/06/2011 (Copy of agenda and attendance available on site) regarding the necessity of following the plans of care exactly, notifying the RN of changes, patient's requests or missed visits.	

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G 225	Continued From page 42 The medical record contained "HOME HEALTH AIDE VISIT RECORD" forms for 15 aide visits provided during Patient #11's admission to the agency, from 2/08/11 through 3/15/11. The following documentation indicated the aide did not provided services in accordance with the POC established by the RN: - None of the 15 visits contained documentation light housekeeping services were provided. - None of the 15 visits contained documentation the aide provided oral care for Patient #11. - All of the 15 visits contained documentation the aide provided foot care for Patient #11. - Only the visits on 2/23/11, 2/25/11, 3/01/11, and 3/12/11 contained documentation the aide assisted Patient #11 with a shampoo and hair care. The DON reviewed Patient #11's medical record on 8/26/11 at 1:00 PM. She confirmed the aide did not providing services in accordance with the established POC. Care was not provided to Patient #11 as outlined in the aide POC.	G 225	• Professional staff (RNs and PTs) were instructed to verify aide compliance with the plan of care during supervisory visits on 09/06/2011 (Copy of agenda and attendance available on site) **Who is responsible to implement the corrective action?** The Director of Clinical Services is responsible to ensure compliance. **When will the corrective action be implemented?** Date of Compliance: 09/19/2011. **What is the monitoring process we will put in place to ensure implementation and effectiveness of the corrective action plan?** The Director of Clinical Services or designee will audit the records of 100% of the clinical records of patients receiving aide services to ensure home health aide care follows the Plans of Care until compliance is achieved. Then, the QI staff will assume responsibility for monitoring during routine audits, notifying the DCS if problems are noted. Trends of problems identified will be reported to the QI committee. Quarterly clinical record review will include evaluating whether the care provided follows the written plan of care.	
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.	G 229	**CMS STD: G229** **CMS CFR:** 484.36 (d)(2) **Evidence:** The agency failed to demonstrate home health aides supervisory visits were conducted every 14 days.	

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G 229	Continued From page 43 This STANDARD is not met as evidenced by: Based on record review, review of facility policies, and interview it was determined the agency failed to ensure home health aide supervisory visits were conducted every 14 days for 2 of 2 sample patients (#4 and #11) who received home health aide services. This had the potential to interfere with quality and safety of patient care. Findings include: 1. The "HOME HEALTH AIDE SUPERVISION" policy, undated, indicated when skilled services were provided to a patient, an RN or a Therapist were to complete a supervisory visit to the patient's residence "at least every 2 weeks to assess relationships and determine whether goals are being met." In addition, the policy indicated the aide visit record was to be reviewed by the supervising RN/Therapist to "assure services are being provided according to the care plan." Home health aide supervision was not completed as required in the following examples: a. Patient #11 was a 74 year old female admitted to the agency on 2/08/11 for care related to diabetes, skin breakdown, and morbid obesity. She was discharged from services on 3/15/11. Her "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 2/08/11 through 4/08/11, contained physician orders for SN and home health aide services 3 times a week. Patient #11's medical record did not contain documentation that on-site aide supervisory visits	G 229	**Agency response: What action will we take to correct the deficiency cited?** • The RNs caring for Patients #4 and #11 were counseled regarding documentation of onsite aide supervisory visits at a minimun of every 14 days. • All direct care staff were in-serviced on 09/06/2011 (Copy of agenda and attendance available on site) regarding completing and documenting onsite home health aide supervisory visits at a minimum of every 14 days. **Who is responsible to implement the corrective action?** The Director of Clinical Services is responsible to ensure compliance. **When will the corrective action be implemented?** Date of Compliance: 09/19/2011. **What is the monitoring process we will put in place to ensure implementation and effectiveness of the corrective action plan?** The DCS or designee will audit 100 % of active patient records receiving Home Health Aide services monthly for compliance with supervision. Once compliance is 98% or above for 2 consecutive months then the DCS or designee will audit at least 10% of the monthly census to ensure supervision is completed and compliant. Trends of problems identified will be reported to the PI committee.	

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G 229	Continued From page 44 had been completed during her admission from 2/08/11 through 3/15/11. Patient #11's "HOME HEALTH AIDE CARE PLAN," completed by an RN on 2/08/11, included orders for the aide to assist with hair care/shampoo and provide oral care with each visit. In addition, the aide was to assist with light housekeeping in the bedroom and bathroom on a weekly basis. The RN did not include instructions for the aide to provide foot care. The medical record contained "HOME HEALTH AIDE VISIT RECORD" forms for 15 aide visits provided during Patient #11's admission to the agency, from 2/08/11 through 3/15/11. The following documentation indicated the aide did not provided services in accordance with the POC established by the RN: - None of the 15 visits contained documentation light housekeeping services were provided. - None of the 15 visits contained documentation the aide provided oral care for Patient #11. - All of the 15 visits contained documentation the aide provided foot care for Patient #11. - Only the visits on 2/23/11, 2/25/11, 3/01/11, and 3/12/11 contained documentation the aide assisted Patient #11 with a shampoo and hair care. The DON reviewed Patient #11's medical record on 8/26/11 at 1:00 PM. She confirmed the record did not contain documentation to indicate aide supervisory visits had been conducted. She	G 229	Quarterly clinical record review will include evaluating whether supervision is completed every 2 weeks for Home Health Aide. The PI committee will review audits and quarterly clinical record review and develop action plans until identified problems are resolved	

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	137111	A. BUILDING _____ B. WING _____	08/29/2011

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G 229	Continued From page 45 confirmed the aide's documentation of services provided during visits was not in accordance with the POC. She stated the supervising RN reviewed aide visit notes but was not necessarily comparing the care provided with the care ordered on the aide POC. Supervisory aide visits were not provided as required or per agency policy. b. Patient #4 was a 59 year old male who was admitted to the agency on 4/01/11 for care primarily related to back pain. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification periods 5/31/11 to 7/29/11, included orders for home health aide services for personal care. RN supervisory visits of the home health aide were documented on 6/21/11 and again on 7/14/11. This was 6 days beyond the requirement for supervision every two weeks. The DON was interviewed on 8/25/11 at 4:10 PM. She reviewed Patient #4's record and confirmed the RN supervisory visit was late. There was an undated "HOME HEALTH AIDE CARE PLAN," in Patient #4's record. There was no evidence of nursing review, revision or updates to the care plan from the SOC date (4/01/11) until the date of record review by the surveyor on 8/26/11 (a 21 week period of time). The RN Case Manager was interviewed on 8/26/11 between 8:35 AM and 9:20 AM. She stated the aide care plan was initiated on the SOC date (4/01/11) when she performed the	G 229		

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G 229	Continued From page 46 initial assessment. She further stated she did not review or update the care plan routinely, only if the aide or physical therapist notified her about a problem or concern. She confirmed there was no evidence of review or updating to the aide care plan. The agency did not ensure home health aide supervisory visits were conducted by an RN as required.	G 229		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on record review, staff interview, and patient interview during a home visit, it was determined the agency failed to ensure medications were fully assessed during the initial comprehensive assessment and/or recertification assessments for 1 of 6 patients (#4) visited in their homes, whose records were reviewed. This had the potential to interfere with safety and continuity of patient care. Findings include: Patient #4 was a 59 year old male who was admitted to the agency on 4/01/11 for care primarily related to back pain. A "PHYSICAL THERAPY RECERTIFICATION/FOLLOW-UP ASSESSMENT" was completed by a physical therapist on 5/28/11 and for the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for	G 337	**CMS STD: G337** **CMS CFR:** 484.55 (c) **Evidence:** The agency failed to demonstrate medications were fully assessed during initial comprehensive assessments and/or recertification assessments. **Agency response: What action will we take to correct the deficiency cited?** • Medication list for patient #4 was reviewed and updated with the medication changes on 09/19/2011. The physician for patient #4 was notified of the missing medications; insulin and Oxycodone on the Start of Care Plan of Care dated 4/1/11-5/30/11 and recertification Plan of Care 5/31/11-7/29/1. An order clarifying the medications on the Plans of Care was obtained and sent to the physician on 09/19/2011.	

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G 337	Continued From page 47 certification period 5/31/11 to 7/29/11. The reassessment did not include Patient #4's medications, insulin or Oxycodone. A home visit was conducted on 8/23/11 between 2:00 PM and 3:15 PM. Patient #4 was interviewed regarding his medications. He explained he was on a sliding scale for insulin 4 times per day, Humalog before meals 3 times per day, and Lantus before bedtime. When asked how long he had been on insulin, he stated he had been on insulin since a back surgery, prior to the time the home health agency began seeing him. He also stated he took Oxycodone, up to 6 pills in a 24 hour period. He stated "I take 4 on a good day." He did not state how long he had been taking the Oxycodone. The DON was interviewed on 8/25/11 at 4:10 PM. She reviewed Patient #4's record. She stated the medications were not listed on the SOC, recertification assessment or POC. The RN Case Manager for Patient #4 was interviewed on 8/26/11 between 8:35 AM and 9:20 AM. She stated she was aware Patient #4 was on Lantus insulin at SOC and that it was an "oversight" that it was not placed on the POC. She stated she knew Patient #4 was taking Oxycodone and explained it was mixed with Amitriptyline. She said it must not have been on the POC because of a "clerical error." Physical Therapist A, who performed the recertification assessment on 5/28/11 at 1:10 PM, was interviewed on 8/26/11 at 10:50 AM. He reviewed Patient #4's record and stated that medications were not his strong point. He said	G 337	• The RN and Physical Therapist who provided care to patient #4 were counseled individually by the Director of Clinical Services (DCS) 09/06/2011 regarding performing a thorough drug regimen review and updating the medication lists for all patients at the time of comprehensive assessments and whenever there is a change in medications. • An in-service training session was completed on 09/06/2011__ for all RNs and PTs. The staff was instructed to include all medications ordered by the patient's physician including over the counter medications on the medication profile. Medication lists are to be reviewed and updated by the nurse at least every 60 days and whenever a new, changed or discontinued medication is ordered. (Copy of the attendance and agenda available on site) **Who is responsible to implement the corrective action?** The Director of Clinical Services is responsible for ensuring compliance. **When will the corrective action be implemented?** Date of Compliance: 09/19/2011.	

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G 337	Continued From page 48 he knew Patient #4 was on pain medication but he did not know specifically about the Oxycodone. He stated he did not know about Patient #4's insulin use. The agency did not ensure the comprehensive assessment was updated and revised to include a review of all medications used by Patient #4.	G 337	**What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action?** The DCS or designee will randomly audit 10% of the clinical records monthly to identify any problem or non-compliance with the drug regimen review. The DCS will track and take corrective action to ensure compliance. Quarterly clinical record review will evaluate drug regimen review to ensure that the comprehensive assessment includes a review of all medication and the medication lists are kept updated with new, changed or discontinued medications. The QI committee will monitor the audits of the DCS and the quarterly clinical record review to ensure compliance aud initiate appropriate corrective action until resolved.	

FORM APPROVED

Bureau of Facility Standards

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey for your Home Health Agency. The following surveyors conducted the survey: Aimee Hastriter, RN, BS, HFS, Team leader Teresa Hamblin, RN, MSN, HFS Rebecca Lara, RN, BA, HFS The following acronyms were used in this report: DME - Durable Medical Equipment DON - Director of Nursing HHA - Home Health Agency LPN - Licensed Practical Nurse POC - Plan of Care PTA - Physical Therapy Assistant RN - Registered Nurse TENS - Transcutaneous Electrical Neural Stimulation	N 000	OneSource Home Health Care, LLC State License Survey Plan of Correction N019 Evidence: The organization failed to demonstrate protection of patient's right to privacy during home visits. Agency response: What action will we take to correct the deficiency cited? ▪ The RN was counseled on 9/6/2011 the DCS regarding Patient Rights and the Right to have privacy during home visits. The DCS instructed the RN on ensure the door to the patient's room in the Assisted Living Facility remains closed when completing home visits. ♦ An in-service training session on Patient Rights and the Right to Privacy was completed for all direct care employees on 09/19/2011 (Copy of attendance and agenda available on site) Who is responsible to implement the corrective action? The Director of Clinical Services is responsible to ensure compliance. When will the corrective action be implemented? Date of Compliance: 09/19/2011 What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action? Compliance will be monitored by the Director of Clinical Services or designee. The DCS or designee will perform quarterly random home visits with employees to ensure compliance with following patient's right to privacy.	
N 019	03.07020, ADMIN. GOV. BODY N019 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.i. A patient has the right to: courteous and respectful treatment, privacy, and freedom from abuse and neglect. This Rule is not met as evidenced by: Refer to G101 as it relates to the agency's failure	N 019		

Bureau of Facility Standards

Jennifer Davis — Administrator — 9/19/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Bureau of Facility Standards

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the State licensure survey for your Home Health Agency. The following surveyors conducted the survey: Aimee Hastriter, RN, BS, HFS, Team leader Teresa Hamblin, RN, MSN, HFS Rebecca Lara, RN, BA, HFS The following acronyms were used in this report: DME - Durable Medical Equipment DON - Director of Nursing HHA - Home Health Agency LPN - Licensed Practical Nurse POC - Plan of Care PTA - Physical Therapy Assistant RN - Registered Nurse TENS - Transcutaneous Electrical Neural Stimulation	N 000	OneSource Home Health Care, LLC State License Survey Plan of Correction **N019** **Evidence:** The organization failed to demonstrate protection of patient's right to privacy during home visits. **Agency response: What action will we take to correct the deficiency cited?** • The RN was counseled on 9/6/2011 the DCS regarding Patient Rights and the Right to have privacy during home visits. The DCS instructed the RN on ensure the door to the patient's room in the Assisted Living Facility remains closed when completing home visits. • An in-service training session on Patient Rights and the Right to Privacy was completed for all direct care employees on 09/19/2011 (Copy of attendance and agenda available on site) **Who is responsible to implement the corrective action?** The Director of Clinical Services is responsible to ensure compliance. **When will the corrective action be implemented?** Date of Compliance: 09/19/2011 **What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action?** Compliance will be monitored by the Director of Clinical Services or designee. The DCS or designee will perform quarterly random home visits with employees to ensure compliance with following patient's right to privacy.	
N 019	03.07020. ADMIN. GOV. BODY N019 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.i. A patient has the right to: courteous and respectful treatment, privacy, and freedom from abuse and neglect. This Rule is not met as evidenced by: Refer to G101 as it relates to the agency's failure	N 019		

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N 019	Continued From page 1 to protect and promote a patient's right to privacy.	N 019	N058 **Evidence:** The organization failed to ensure the contracts utilized for therapy and dietary services clearly indicated the manner in which services would be monitored and staff expectations.	
N 058	03.07021. ADMINISTRATOR N058 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: h. Insuring that if personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following: v. The manner in which services will be controlled, coordinated, and evaluated by the primary agency; This Rule is not met as evidenced by: Refer to G142 as it relates to the agency's failure to ensure contractual agreements utilized by the HHA were clear and complete.	N 058	**Agency response: What action will we take to correct the deficieney cited?** • A new contract for therapy services was implemented on 09/19/2011. The new contract was obtained from a commercially published manual and it has been reviewed and signed by the organization and all contracted therapy agencies/staff on or by 09/30/2011. (Copy of new contract available on site) • The new contract includes: 1. Patients are accepted for care only by the primary HHA. 2. The services to be furnished. 3. The necessity to conform to all applicable agency policies including personnel qualifications. 4. The responsibility for participating in developing plans of care. (continued on next page)	
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 G144 as it relates to the agency's failure	N 062	N062 **Evidence:** The organization failed to demonstrate coordination of care was clearly documented in clinical records or minutes of case conferences. **Agency response: What action will we take to correct the deficiency cited?** • The PTAs and PTs for Patient #1 and #10 were counseled on 09/06/2011 regarding documenting coordination of care between PT and PTA, patient, family and ALF.	

N058

5. The manner in which services will be controlled, coordinated and evaluated by the primary HHA.
6. The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation.
7. The procedure for payment for services furnished under the contract.

- The Therapy Supervisor has been in-serviced on or by 09/30/2011 regarding the new contract and the required elements for compliance.

Who is responsible to implement the corrective action?
The Administrator is responsible to ensure compliance.

When will the corrective action be implemented?
Date of Compliance: 09/30/2011.

What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action?

The Administrator will review the contract annually with the contracting therapies and dietary to discuss any changes or adjustments.

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N 062	Continued From page 2 to ensure documentation of coordination of care.	N 062	• The PTA for Patient #4 was counseled on 09/06/2011 regarding notifying PT immediately of changes in patients' conditions and notifying the physician or PT if blood glucose is above or below written parameters. See additional...	
N 102	03.07024.SK.NSG.SERV. N102 01.Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: j. For patients receiving care from a licensed practical nurse, the registered nurse reviews the plan of care and nursing services received at least every two (2) weeks and documents this in the patient's medical record. This Rule is not met as evidenced by: Based on record review, review of agency policies, review of state licensing rules, and staff interview it was determined the agency failed to ensure LPN supervisory visits were conducted and documented in accordance with state licensing rules. This impacted 1 of 2 sample patients (#11) who received care from an LPN. Failure to adhere to state licensing rules for supervision resulted in a delay in re-evaluating a patient's needs and had the potential to result in inadequate provision of care. Findings include: 1. State licensing rules for HHAs found at IDAPA 16.03.07.024.01.j, require that for "patients receiving care from a licensed practical nurse, the registered nurse reviews the plan of care and nursing services received at least every two (2) weeks and documents this in the patient's medical record."	N 102	N102 **Evidence:** The organization failed to demonstrate compliance with state licensing regulations for LPN and PTA supervision. **Agency response: What action will we take to correct the deficiency cited?** • The policy for LPN supervision was amended on 09/06/2011 to reflect Idaho state licensing regulations for LPN every 14 days. (Copy of policy available on site.) • PTA supervision to be completed by the Physical Therapist PT on the 5th visit was included in the therapy contract. 09/19/2011. (Copy of contract available on site.) • An in-service training session for all direct care employees was completed on 09/06/2011. The employees were instructed on the frequency of supervision for LPNs and PTAs and reviewing LPN and PTA notes to ensure the plan of care is followed. (Copy of attendance and agenda available on site) **Who is responsible to implement the corrective action?** The Director of Clinical Services and Therapy supervisor is responsible to ensure compliance. **When will the corrective action be implemented?** Date of Compliance: 09/19/2011. **What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action?**	

- The PT for Patient #4 was counseled on 09/06/2011 regarding documenting changes in the patient's plan of care and instructing PTA of changes.
- The PTA and the PT for Patient #2, #7 were counseled on 09/06/2011 regarding documenting coordination of care and notification of changes in the patient's condition.
- The PTA for Patient #5 was counseled on 09/06/2011regarding reporting Emergency Department visits and reporting changes in patients' condition immediately to ALF and PT.
- An In-service training session for all direct care staff was completed on 09/06/2011. (Copy of attendance and agenda available on site) The in-service training session included:
- Notifying supervisors of changes in patient conditions and Emergency Department visits immediately
- Notifying ALF of changes in patient conditions
- Documenting notification to supervisor on progress note or a communication note.
- An In-service training session on Diabetes Management and Reporting changes to Physicians was completed on 09/06/2011 for all nursing staff (LPNs and RNs). (Copy of attendance and agenda available on site) The In-service training session consisted of:
- Documenting notification from ALF regarding blood glucose levels that are above or below parameters.
- Notifying the physician of patient's whose blood glucose levels that are above or below parameters and documenting notification.
- Documenting interventions provided from ALF or SN when a patient's blood glucose level was above or below parameters.
- Documenting coordination of care between ALF and home health staff.

Who is responsible to implement the corrective action?
The Director of Clinical Services is responsible to ensure compliance.

When will the corrective action be implemented?
Date of Compliance: 09/19/2011.

What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action?
The DCS or designee will audit the records of 100 % of the census until compliance is evident, and then 10% of the monthly census to ensure coordination of care is completed and documented and notification to physician is completed and documented. Trends of problems identified will be reported to the PI committee. Quarterly clinical record review will include evaluating the timeliness of coordination of care, coordination between all disciplines involved and whether coordination of care is documented. The PI committee will review audits and quarterly clinical record review and develop action plans until identified problems are resolved.

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N 102	Continued From page 3 The agency policy "LICENSED PRACTICAL NURSE SUPERVISION," undated, was reviewed. According to the policy, the RN supervisory visit may be completed directly while the LPN provided services to the patient, or indirectly by alternating visits with the LPN and RN. In addition, if an LPN provided care to a patient whose condition was unstable, or whose care plan was complex, the policy indicated, "If the LPN has demonstrated competency in and is assigned to provide care to clients with complex needs, the Registered nurse [sic] will supervise and instruct the LPN on the first day of assignment and as often as deemed necessary but no less than every thirty (30) [sic] thereafter." The agency policy did not accurately reflect the state licensing rules related to LPN supervision. LPN supervision was not provided in accordance with state licensing rules, as follows: Patient #11 was a 74 year old female admitted to the agency on 2/08/11 for care related to diabetes, skin breakdown, and morbid obesity. She was discharged from services on 3/15/11. Her "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 2/08/11 through 4/08/11, contained physician orders for SN services 3 times a week. The DON was interviewed on 8/25/11 at 3:30 PM. She stated it was the agency's practice, and policy, for the RN to either accompany the LPN on a visit or go instead of the LPN to evaluate nursing services provided. She stated this was occurring on a monthly basis. She stated she was not aware of the state licensing requirements of reviewing the plan of care and LPN nursing	N 102	The DCS or designee will audit 100 % of active patient records receiving LPN or PTA services monthly for compliance with supervision. Once compliance is 98% or above for 2 consecutive months then the DCS or designee will audit at least 10% of the monthly census to ensure supervision is completed and compliant. Trends of problems identified will be reported to the PI committee. Quarterly clinical record review will include evaluating whether supervision is completed every 2 weeks for LPN and every 5th visit for PTA. The PI committee will review audits and quarterly clinical record review and develop action plans until identified problems are resolved	

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N 102	Continued From page 4 services every two weeks. She confirmed that Patient #11's medical record did not contain documentation of an RN review of the POC and LPN nursing services every two weeks. LPN supervision was not conducted and documented in accordance with state licensing rules.	N 102		
N 119	03.07024.04.SK.NSG.SERV. N119 04. Supervisory Visits. A registered nurse or therapist makes a supervisory visit to the patient's residence at least every two (2) weeks, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are met. For patients who are receiving only home health aide services, a supervisory visit must be made at least every sixty (60) days. This Rule is not met as evidenced by: Refer to G229 as it relates to the agency's failure to ensure home health aide supervisory visits were completed every 14 days.	N 119	N119 **Evidence:** The agency failed to demonstrate home health aides supervisory visits were conducted every 14 days. **Agency response: What action will we take to correct the deficiency cited?** • The RNs caring for Patients #4 and #11 were counseled regarding documentation of onsite aide snpervisory visits at a mininum of every 14 days. • All direct care staff were in-serviced on 09/06/2011 (Copy of agenda and attendance available on site) regarding completing and documenting onsite home health aide supervisory visits at a minimum of every 14 days.	
N 123	03.07025.THERAPY SERV. N123 025. THERAPY SERVICES. Any therapy services offered by the HHA directly or under arrangement are given by a qualified therapist or by a qualified therapy assistant under the supervision of a qualified therapist and in accordance with the plan of care.	N 123	N123 **Evidence:** The agency failed to demonstrate PTA services were provided in accordance with the plan of care. **Agency response: What action will we take to correct the deficiency cited?** • The PTA for Patient # 5 was counseled on 09/06/2011 regarding following the patient's plan of care and notifying PT for changes in the patient's plan of care and DME needs. The PTA shall document coordination of care and changes made by the PT on their visit note.	

Who is responsible to implement the N119 corrective action?
The Director of Clinical Services is responsible to ensure compliance.

When will the correetive action be implemented?
Date of Compliance: 09/19/2011.

What is the monitoring process we will put in place to ensure implementation and effectiveness of the corrective action plan?

The DCS or designee will audit 100 % of active patient records receiving Home Health Aide services monthly for compliance with supervision. Once compliance is 98% or above for 2 consecutive months then the DCS or designee will audit at least 10% of the monthly census to ensure supervision is completed and compliant. Trends of problems identified will be reported to the PI committee.

Quarterly clinical record review will include evaluating whether supervision is completed every 2 weeks for Home Health Aide. The PI committee will review audits and quarterly clinical record review and develop action plans until identified problems are resolved

Bureau of Facility Standards

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	137111	A. BUILDING _____ B. WING _____	08/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONESOURCE HOME HEALTH	3544 EAST 17TH STREET SUITE 201 IDAHO FALLS, ID 83406

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N 123	Continued From page 5 This Rule is not met as evidenced by: Refer to G185 as it relates to the agency's failure to ensure a PTA services were provided in accordance with the POC.	N 123	• An In-service training session for all PTAs on following the Plan of Care was completed on 09/06/2011. (Copy of attendance and agenda available on site) The In-service training session consisted of: Continued on next page **N153** **Evidence:** The organization failed to demonstrate relevant information was included in patients' plans of care.	
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: a. All pertinent diagnoses; This Rule is not met as evidenced by: Based on record review, staff interview, and patient interview it was determined the agency failed to ensure the plan of care included all relevant information for 1 of 12 patients (#7) whose records were reviewed. This had the potential to interfere with quality and coordination of patient care. Findings include: 1. Patient #7 was a 79 year old male who was admitted to the agency on 5/23/11 for care related to difficulty walking and an abnormal brain condition called normal pressure hydrocephalus. An RN's Summary Note attached to the "COMPREHENSIVE ADULT NURSING ASSESSMENT," dated 5/23/11, stated Patient #7 underwent surgery to place a shunt in the right side of his head related to the normal pressure hydrocephalus. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE, for certification period 7/22/11 to 9/19/11, did not include information related to the surgery.	N 153	**Agency response: What action will we take to correct the deficiency cited?** • The physician for patient #7 was notified of the missing surgical diagnosis for the plan of care dated 7/22/11-9/19/11 and a clarification order was obtained to add stent diagnosis to the plan of care. • The nurse caring for patients #7 was counseled individually to apprise them of errors and state expectations for the future. • In-service education program for all direct care staff regarding the agency's policy on Plan of Care and ensuring relevant information was included in patients' plans of care was completed on 09/06/2011. (Copy of agenda and attendance on site) Staff were instructed to: • Include all pertinent diagnoses (both principle and secondary) with dates of onset to the plan of care • Include all DME used by the patient or therapist on the plan of care • Ensure all allergies and medications are listed on the plan of care • Include all treatments and interventions on the plan of care • Staff shall review each plan of care for completeness and accuracy prior to signing and prior to sending to physician for signature.	

N 123

- Following the plan of care as assigned by the Physical Therapist.
- Notify the Physical Therapist of changes in the patient's condition
- Notify the Physical Therapist of any missed visits.
- Documenting coordination of care and notification of changes on their progress note.

Who is responsible to implement the corrective action?
The Director of Clinical Services is responsible to ensure compliance.

When will the corrective action be implemented?
Date of Compliance: 09/19/2011.

What is the monitoring process we will put in place to ensure implementation and effectiveness of the corrective action plan?

The Director of Clinical Services or Therapy Supervisor will audit monthly 100% of the patient records receiving PTA services to ensure the PTAs follow the patient's plan of care. Trends of problems identified will be reported to the QI committee.

Quarterly clinical record review will include evaluating whether the care provided follows the written plan of care. The PI committee will review audits and quarterly clinical record

reviews and develop action plans until identified problems are resolved.

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N 153	Continued From page 6 The DON was interviewed on 8/25/11 at 3:40 PM. She reviewed Patient #7's record and confirmed the information was missing from the POC. The agency's "PLAN OF CARE" policy, undated, was reviewed. According to the policy, the POC was to contain, among other elements, all pertinent diagnoses (both principle and secondary) with dates of onset, specific procedures and modalities for therapy services, and medical supplies and equipment required. The agency did not ensure a relevant diagnosis was included in the POC.	N 153	**Who is responsible to implement the corrective action?** The Director of Clinical Services is responsible to ensure compliance. **When will the corrective action be implemented?** Date of Compliance: 09/19/2011. **What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action?** The DCS or designee will audit 100% of the initial and recertification plans of care monthly to ensure completeness, accuracy and compliance. Continued from page 6 **N155** **Evidence:** The organization failed to demonstrate relevant information including types of services and equipment required was included in patients' plans of care. **Agency response: What action will we take to correct the deficiency cited?** • The physician for patient #4 was notified of the missing items on the plan of care and a clarification order was written to TENS unit to the recertification plan of care dated 7/30/11-9/27/11. • The physician for patient #1 was notified of the missing items to the plan of care dated 6/10/11-8/08/11 and a clarification order was obtained to add DME supplies; wheelchair and walker to the plan of care. • In-service education program for all direct care staff regarding the agency's policy on Plan of Care and ensuring relevant information was included In patients' plans of care was completed on 09/06/2011. (Copy of agenda and attendance on site) Staff were instructed to:	
N 155	03.07030. PLAN OF CARE N155 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: c. Types of services and equipment required; This Rule is not met as evidenced by: Based on record review, staff interview, and patient interview it was determined the agency failed to ensure the plan of care included all relevant information for 2 of 12 patients (#1 and #4) whose records were reviewed. This had the potential to interfere with quality and coordination of patient care. Findings include: 1. Patient #4 was a 59 year old male who was admitted to the agency on 4/01/11 for care	N 155		

N153

Trends of problems identified will be reported to the PI committee.
Quarterly clinical record review will include evaluating Plans of Care for completeness and all pertinent information. The PI committee will review audits and quarterly clinical record reviews and develop action plans until identified problems are resolved

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N 155	Continued From page 7 primarily related to back pain. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for certification periods 5/31/11 to 7/29/11 and 7/30/11 to 9/27/11, included a diagnosis of diabetes. The POC did not include a TENS unit as part of supplies utilized by Patient #4. A PTA visit note, dated 7/18/11 at 2:10 PM referenced Patient #4 using a TENS unit. This was not on the POC. Physical Therapist A was interviewed on 8/26/11 at 10:50 AM. He reviewed Patient #4's record and confirmed the TENS unit should have been included in the POC. The agency did not ensure a TENS unit was included on Patient #4's POC. 2. Patient #1 was an 80 year old female admitted to the agency on 4/11/11 for therapy services to improve ambulation. She was discharged from the agency on 8/08/11. The "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 6/10/11 through 8/08/11, was missing the following information: The section related to DME and supplies indicated Patient #1 was not using additional medical equipment for her therapy. However, the POC indicated the activities permitted for Patient #1 included being up as tolerated and using a wheelchair and a walker. In addition, one of the therapy goals for Patient #1 was to ambulate with a front wheeled walker with only stand-by assistance. The DON reviewed Patient #1's medical record	N 155	• Include all pertinent diagnoses (both principle and secondary) with dates of onset to the plan of care • Include all DME used by the patient or therapist on the plan of care • Ensure all allergies and medications are listed on the plan of care • Include all treatments and interventions on the plan of care • Staff shall review each plan of care for completeness and accuracy prior to signing and prior to sending to physician for signature. **Who is responsible to implement the corrective action?** The Director of Clinical Services is responsible to ensure compliance. **When will the corrective action be implemented?** Date of Compliance: 09/19/2011. **What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action?** The DCS or designee will audit 100% of the initial and recertification plans of care monthly to ensure completeness, accuracy and compliance. Trends of problems identified will be reported to the PI committee. Quarterly clinical record review will include evaluating Plans of Care for completeness and all pertinent information. The PI committee will review audits and quarterly clinical record reviews and develop action plans until identified problems are resolved	

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N 155	Continued From page 8 on 8/25/11 at 3:30 PM. She confirmed the DME and supplies were not listed on the POC. The agency's "PLAN OF CARE" policy, undated, was reviewed. According to the policy, the POC was to contain, among other elements, all pertinent diagnoses (both principle and secondary) with dates of onset, specific procedures and modalities for therapy services, and medical supplies and equipment required. The POC did not include the DME and supplies Patient #1 utilized.	N 155		
N 161	03.07030.PLAN OF CARE N161 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: i. Medication and treatment orders; This Rule is not met as evidenced by: Based on record review, staff interview, and patient interview it was determined the agency failed to ensure the plan of care included all relevant information for 1 of 12 patients (#4) whose records were reviewed. This had the potential to interfere with quality and coordination of patient care. Findings include: Patient #4 was a 59 year old male who was admitted to the agency on 4/01/11 for care primarily related to back pain. The "HOME HEALTH CERTIFICATION AND PLAN OF	N 161	**N161** **Evidence:** The organization failed to demonstrate relevant information including medication and treatment was included in patients' plans of care. **Agency response: What action will we take to correct the deficiency cited?** • The physician for patient #4 was notified of the missing items on the plan of care and a clarification order was written to add Insulin: Lantus and Humalog sliding scale and Oxycodone to the recertification plan of care dated 7/30/11-9/27/11. • The nurse caring for patients #4 was counseled individually to apprise them of errors and state expectations for the future. • In-service education program for all direct care staff regarding the agency's policy on Plan of Care and ensuring relevant information was included in patients' plans of care was completed on 09/06/2011. (Copy of agenda and attendance on site) Staff were instructed to:	

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N 161	Continued From page 9 CARE," for certification periods 5/31/11 to 7/29/11 and 7/30/11 to 9/27/11, included a diagnosis of diabetes. The POC did not include his medications, insulin or Oxycodone. A home visit was conducted on 8/23/11 between 2:00 PM and 3:15 PM. Patient #4 was interviewed regarding his medications. He explained he was on a sliding scale for insulin 4 times per day, Humalog before meals 3 times per day, and Lantus before bedtime. When asked how long he had been on insulin, he stated he had been on insulin since a back surgery, prior to the time the home health agency began seeing him. He also stated he took Oxycodone, up to 6 pills in a 24 hour period. He stated "I take 4 on a good day." The DON was interviewed on 8/25/11 at 4:10 PM. She reviewed Patient #4's record. She stated she was not aware Patient #4 was on insulin or on Oxycodone. She confirmed the medications were not on the POC. The RN Case Manager for Patient #4 was interviewed on 8/26/11 between 8:35 AM and 9:20 AM. She stated she was aware Patient #4 was on Lantus insulin and that it was an "oversight" that it was not placed on the POC. She stated she did not know about the Humalog insulin. She stated she was aware Patient #4 was taking Oxycodone, stating it was mixed with Amitriptiline. She described its omission from the POC as a "clerical error." The agency's "PLAN OF CARE" policy, undated, was reviewed. According to the policy, the POC was to contain, among other elements, all pertinent diagnoses (both principle and secondary) with dates of onset, specific	N 161	• Include all pertinent diagnoses (both principle and secondary) with dates of onset to the plan of care • Include all DME used by the patient or therapist on the plan of care • Ensure all allergies and medications are listed on the plan of care • Include all treatments and interventions on the plan of care • Staff shall review each plan of care for completeness and accuracy prior to signing and prior to sending to physician for signature. **Who is responsible to implement the corrective action?** The Director of Clinical Services is responsible to ensure compliance. **When will the corrective action be implemented?** Date of Compliance: 09/19/2011. **What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action?** The DCS or designee will audit 100% of the initial and recertification plans of care monthly to ensure completeness, accuracy and compliance. Trends of problems identified will be reported to the PI committee. Quarterly clinical record review will include evaluating Plans of Care for completeness and all pertinent information. The PI committee will review audits and quarterly clinical record reviews and develop action plans until identified problems are resolved	

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N 161	Continued From page 10 procedures and modalities for therapy services, and medical supplies and equipment required. The POC did not include all of Patient #4's medications.	N 161		
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G337 as it relates to the agency's failure to ensure comprehensive medication reviews during initial or recertification assessments.	N 173	N173 **Evidence:** The agency failed to demonstrate medications were fully assessed during initial comprehensive assessments and/or recertification assessments. **Agency response: What action will we take to correct the deficiency cited?** • Medication list for patient #4 was reviewed and updated with the medication changes on 09/19/2011. • The physician for patient #4 was notified of the missing medications; insulin and Oxycodone on the Start of Care Plan of Care dated 4/1/11-5/30/11 and recertification Plan of Care 5/31/11-7/29/1. An order clarifying the medications on the Plans of Care was obtained and sent to the physician on 09/19/2011. • The RN and Physical Therapist who provided care to patient #4 were counseled individually by the Director of Clinical Services (DCS) 09/06/2011_ regarding performing a thorough drug regimen review and updating the medication lists for all patients at the time of comprehensive assessments and whenever there is a change in medications. • An in-service training session was completed on 09/06/2011 for all RNs and PTs. The staff was instructed to include all medications ordered by the patient's physician including over the counter medications on the medication profile. Medication lists are to be reviewed and updated by the nurse at least every 60 days and whenever a new, changed or discontinued medication is ordered. (Copy of the attendance and agenda available on site) see next page	

N173

Who is responsible to implement the corrective action?
The Director of Clinical Services is responsible for ensuring compliance.

When will the corrective action be implemented?
Date of Compliance: 09/19/2011.

What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action?

The DCS or designee will randomly audit 10% of the clinical records monthly to identify any problem or non-compliance with the drug regimen review. The DCS will track and take corrective action to ensure compliance.

Quarterly clinical record review will evaluate drug regimen review to ensure that the comprehensive assessment includes a review of all medication and the medication lists are kept updated with new, changed or discontinued medications.

The QI committee will monitor the audits of the DCS and the quarterly clinical record review to ensure compliance and initiate appropriate corrective action until resolved.