

COPY



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7007 3020 0001 3745 8078

January 4, 2012

Cathy Tarbet, Administrator
Access Home Care, LLC
74 West 100 North
Logan, UT 84321

RE: Access Home Care, LLC, Provider #137110

Dear Ms. Tarbet:

Based on the survey completed at Access Home Care, LLC, on December 19, 2011, by our staff, we have determined Access Home Care, LLC is out of compliance with the Medicare Home Health Agency (HHA) **Condition of Participation of Acceptance of Patients, Plan of Care, and Medical Supervision (42 CFR 484.18)**. 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 Access Home Care, LLC, 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;

Cathy Tarbet, Administrator
January 4, 2012
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- 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 February 2, 2012. 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 January 25, 2012.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **January 17, 2012.**

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

TH/srm

Enclosures

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

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

PRINTED: 01/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/19/2011
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NAME OF PROVIDER OR SUPPLIER ACCESS HOME CARE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 240 WEST BURNSIDE AVENUE, SUITE B CHUBBUCK, ID 83202
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G 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during a recent recertification survey of your home health agency.</p> <p>The surveyors conducting the recertification were:</p> <p>Teresa Hamblin, RN, MS, HFS, Team Leader Rebecca Lara, RN, BA, HFS</p> <p>Acronyms used in this report include:</p> <p>ADL = Activities of Daily Living ALF = Assisted Living Facility APS = Adult Protective Services CNA = Certified Nursing Assistant CPAP = Continuous Positive Airway Pressure DM = Diabetes Mellitus DON = Director of Nursing HTN = Hypertension IDT = Interdisciplinary Team IU = International Units LPN = Licensed Practical Nurse MG = Milligrams OT = Occupational Therapist OTC = Over the Counter POC = Plan of Care PT = Physical Therapist RN = Registered Nurse ROC = Resumption of Care SN = Skilled Nursing SOC = Start of Care</p>	G 000	<p>Initial Comments-</p> <p>The Plan of Corrections has been reviewed and accepted by the Administrator, Director of Patient Care Services (DON), and the Governing Body. Full compliance to the following deficiencies will be in effect January 25, 2012</p> <p style="text-align: center;">RECEIVED JAN 17 2012 FACILITY STANDARDS</p>	
G 143	<p>484.14(g) COORDINATION OF PATIENT SERVICES:</p> <p>All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in</p>	G 143	<p>G143- IDT/Communication</p> <p>An in-service will be given to all staff regarding policy and procedure 2030 "coordination</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Beth Cooper* TITLE *Administrator* (X6) DATE *1/16/12*

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

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G 143	Continued From page 1 the plan of care. This STANDARD is not met as evidenced by: Based on record review, observation and staff interview, and interview with a patient's family member, it was determined the agency failed to ensure effective coordination of care among all disciplines and services providing care to 1 of 6 sample patients (#3) who received home visits and had more than one assigned discipline from the agency. This failure had a negative impact on patient safety. Findings include: Patient #3 was an 81 year old female who lived alone and was admitted to the home health agency on 11/02/11. She was diagnosed with muscle weakness, lumbago, Alzheimer's Disease, dementia and coronary artery disease. The "Home Health Certification and Plan of Care," for certification period 11/02/11 to 12/31/11, included orders for skilled nursing, physical therapy and home health aide services. The initial RN assessment, "SN SOC/ROC," dated 11/02/11 and timed 2:59 PM, documented Patient #3 had impaired decision-making abilities and memory loss to the extent that supervision was required. The SOC assessment also documented Patient #3 was a fall risk and recommended the following safety measures: standard precautions, fall precautions, hand rails, clear pathways and safety in ADL's. The recommended safety measures were included as orders on the "Home Health Certification and Plan of Care," for certification period 11/02/11 to 12/31/11.	G 143	of services" (attached as addendum 1) and policy 2037 "Home Safety" (attached as addendum 2). This in-service will be given by the Director of Patient Care Services and will be held on January 18, 2012. In this in-service it will be discussed what topics are needed to be brought before the IDT team, including, safety in the home, changes in patient condition, when to make referrals to social work, and/or APS, and when to bring concerns to your direct supervisor. The IDT case conference agenda will have a section addressed for patients that have change in conditions, are not safe in the home, and/or need a referral to SW or an outside agency. The changes on the form will be made and available for all staff for the IDT meeting for HC that will be held on January 25, 2012. All staff will be made aware of	

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G 143	<p>Continued From page 2</p> <p>A "COMMUNICATION FORM" completed by the RN on 11/15/11 and timed 11:00, with no AM or PM designation, documented Patient #3 was found in the home "half dressed." The RN also documented the oven was found on, with the oven door open, and two stove top burners on and unattended. The RN documented she reported the finding to Patient #3's son. No documentation was found that indicated the findings were reported to the physician or other members of the IDT.</p> <p>A home visit was conducted with Patient #3 on 12/13/11, from 12:50 PM to 1:50 PM. The home health aide was observed while assisting Patient #3 with bath and personal hygiene care. Because Patient #3 was so unsteady when walking, the aide held on to and guided Patient #3 when moving through the apartment. The floors were found to be cluttered with numerous fall hazards. The fall hazards included stairs, throw rugs, clothing items, shoes, boxes, bags, small tables, decorative items and suit cases. The surveyor assessed the kitchen for potential safety hazards and found a stove top burner on and unattended. The surveyor turned off the burner and discussed the fire hazard the home health aide and Patient #3. The aide stated she planned to report the visit activities, including the fire safety hazard to the RN and family.</p> <p>Patient #3's son was interviewed by telephone on 12/14/11 at 8:55 AM. He stated his mother wandered outside the prior evening and fell and fractured her hip. He also stated he had been aware that his mother had left on burners. He explained he tried to remind his mother to use the microwave instead of the burner.</p>	G 143	<p>the changes to the IDT agenda on the January 18, 2012 in-service that is discussed above. The director of patient care services will monitor to make sure this update is made and is utilized on the January 25, 2012 IDT meeting.</p> <p>The Director of Patient Care Services has arranged with APS to come give the IDT team an in-service on when it is appropriate to refer a patient to APS. This in-service will happen on January 19, 2012 at 10am in the Pocatello office.</p> <p>Full compliance of this regulation will be meet by January 25, 2012.</p>	

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G 143	Continued From page 3 The PT assigned to Patient #3 was interviewed on 12/14/11, from 10:35 AM to 10:50 AM. The PT stated Patient #3 had improved and was becoming stronger and less unsteady on her feet. When informed of the unsteady gait and need for hands on assistance, observed during the 12/13/11 home visit, the PT stated he was unaware that Patient #3 was so unsteady that she required constant assistance from the aide when walking. When the recent fall and hip fracture was discussed with the PT, he stated he was informed of the fall that occurred the night before, but was not aware of Patient #3's increasing confusion and increased need for hands-on assistance. On 12/14/11, from 12:30 PM to 12:55 PM, an interview was conducted with the RN assigned to Patient #3. When questioned about the information documented on the 11/15/11 communication form, which stated the oven and stove top burners were discovered on and unattended, the RN stated she did not report the findings to the physician, DON or other IDT members. When asked the reason she did not report these serious safety concerns, the RN stated though she was concerned about Patient #3 living alone, she reported to Patient #3's son and was confident the family was adequately caring for the patient. When asked if she had considered a referral to APS, she stated she was hesitant to contact APS because she had a "bad experience" related to a different patient. When asked if she had initiated a referral to social services, she stated she did not feel a social services evaluation was necessary because the patient's son assured her Patient #3's needs were	G 143			

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G 143	Continued From page 4 being met. The DON was interviewed on 12/15/11, from 10:50 AM to 11:15 AM. Safety hazards related to Patient #3 were discussed. The DON said she had not been informed of the safety hazards and was unaware social services was not assigned to Patient #3. She said it was the practice of the agency to assign social services to any patient who lived alone and was diagnosed with dementia or Alzheimer's disease. She stated social services should have been involved with Patient #3. The DON also stated the agency was not hesitant to consult with APS when necessary. The agency policy entitled, "COORDINATION OF SERVICES," documented the following: "All agency personnel, including providers under contractual arrangement, providing care, treatment and/or services to [name of agency] patients maintain liaison with other healthcare team members to ensure effective coordination of efforts and to support the goals and objectives outlined in the plan of care." The policy also documented, "Communication is maintained between those providing services regarding changes in the patient's needs, services or care to be provided or goals that impact the overall care, treatment and/or services."	G 143			
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 156			

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G 156	Continued From page 5 This CONDITION is not met as evidenced by: Based on observation, staff and patient interview, and review of medical records and agency policies, it was determined the agency failed to ensure care was provided in accordance with patients' POCs, failed to ensure that the POCs included all pertinent information, or failed to ensure physicians were alerted to changes in patient conditions for 5 of 13 patients, (#2, #3, #7, #8, and #9) whose records were reviewed. The cumulative effect of these negative systemic practices impeded the agency in providing safe and effective care. Findings include: 1. Refer to G158 as it relates to the failure of the agency to ensure staff followed patients' established POCs. 2. Refer to G159 as it relates to the failure of the agency to ensure all pertinent information was addressed in patients' POCs. 3. Refer to G164 as it relates to the failure of the agency to ensure patients' POCs were updated and physicians alerted to changes in patients status.	G 156	G156- 484.18 For this plan of correction please refer to 1- G158 2- G159 3- G164	
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, observation, and	G 158	G158- An in-service will be given to all staff regarding policy and procedure 2020 "care plan implementation" (attached as addendum 3), and diabetic management. This in-service will	

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G 158	<p>Continued From page 6</p> <p>interview with staff, patients, and a patient's family member, it was determined the agency failed to ensure care followed a written plan of care for 5 of 13 patients (#2, #3, #7, #8 and #9) whose records were reviewed. This may have contributed to a patient fall resulting in a hip fracture and had the potential to compromise patients' health. Findings include:</p> <p>1. Patient #3 was an 81 year old female who lived alone and was admitted to the home health agency on 11/02/11. She was diagnosed with muscle weakness, lumbago, Alzheimer's Disease, dementia and coronary artery disease.</p> <p>The RN initial visit, "SN SOC/ROC," dated 11/02/11 and timed 2:59 PM, documented the following information related to Patient #3:</p> <ul style="list-style-type: none"> - impaired decision-making abilities and memory loss to the extent that supervision was required. - a history of falls, including 1-2 falls over the past 3 months. - forgetfulness and a memory deficit, including a "failure to recognize familiar persons/places, inability to recall events of the past 24 hours and significant memory loss so that supervision is required." - Impaired decision-making ability and intermittent confusion in the day and evening. - reminders and assistance required from agency staff and family members when taking prescribed medications. <p>The "Home Health Certification and Plan of Care," dated 11/02/11 to 12/31/11 included orders for the following safety measures for Patient #3: Fall precautions, maintain a safe</p>	G 158	<p>be given by the Director of Patient Care Services on January 18, 2012. Full compliance to this deficiency will be January 25, 2012. The quality assurance nurses will do concurrent audits with weekly reports given to the Director of Patient Care Services. These reports will be discipline specific and show compliance to the plan of care. Director of Patient Care Services or delegated personnel will have a weekly interview with the nurses that have worked less than 6 months with the agency. In this meeting the nurses will review their case load with the Director and make sure that the POC is being followed and patient care needs are met.</p>	

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G 158	<p>Continued From page 7 environment, and clear pathways.</p> <p>A "COMMUNICATION FORM" completed by the RN on 11/15/11 and timed 11:00, with no AM or PM designation, documented Patient #3 was found in the home "half dressed." The RN also documented the oven was found on, with the oven door open, and two stove top burners on and unattended. The RN documented she reported the findings and status of Patient #3 to Patient #3's son.</p> <p>A home visit was conducted with Patient #3 on 12/13/11, from 12:50 PM to 1:50 PM. The home health aide was observed while assisting Patient #3 with bath and personal hygiene care. Patient #3 was observed to be very unsteady on her feet and unable to walk without assistance. To keep her safe and guard against falls, the aide held on to and guided Patient #3 when walking from one location in the apartment to another. The floors were found to be cluttered with numerous fall hazards. The fall hazards included stairs, throw rugs, clothing items, shoes, boxes, bags, small tables, decorative items and suit cases. The surveyor assessed the kitchen for potential safety hazards and found a stove top burner on and unattended. The pathways had not been cleared according to the plan of care. A safe environment had not been maintained according to the plan of care.</p> <p>A telephone interview was conducted on 12/14/11, from 8:50 AM to 9:00 AM, with Patient #3's son. Early in the conversation, the son informed the surveyor Patient #3 had wandered out of doors the evening of 12/13/11, fell and fractured her hip. The plan was then to move</p>	G 158			

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G 158	<p>Continued From page 8</p> <p>Patient #3 to in-patient rehabilitation, and finally to an assisted living facility.</p> <p>On 12/14/11, from 12:30 PM to 12:55 PM, an interview was conducted with the RN assigned to Patient #3. She reviewed Patient #3's record and confirmed the accuracy of the information documented on the 11/15/11 communication form, which stated the RN discovered the oven and stove top burners were on in the home of Patient #3 and left unattended. The RN stated she did not feel Patient #3's home environment was safe and free from potential hazards and said she reported her findings to Patient #3's son. When asked if she was aware of Patient #3's fall, injury, and hospitalization from the prior evening, she stated Patient #3's son had contacted her by telephone that morning to let her know what happened.</p> <p>The DON was interviewed on 12/15/11, from 10:50 AM to 11:15 AM. Safety hazards related to Patient #3 were discussed. The DON stated she was "appalled" when she learned of the safety hazards in Patient #3's home and the fall and hip fracture that occurred the prior evening. She said it was the practice of the agency to assign social services to any patient who lived alone and was diagnosed with dementia or Alzheimer's disease, such as Patient #3. The DON also stated the agency was not hesitant to consult with APS when necessary. The DON confirmed the recommended safety measures documented on the plan of care were not adhered to and resulted in unsafe living conditions for Patient #3.</p> <p>The written plan of care for Patient #3 related to safety measures was not followed.</p>	G 158			

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G 158	<p>Continued From page 9</p> <p>2. Patient #8 was a 52 year old female who was admitted to the agency on 12/02/11. The SOC assessment, dated 5/27/11, 9:26 AM to 11:14 AM, documented Patient #8 with the following diagnoses: spondylosis (age-related wear and tear affecting the disks in the neck that later contribute to arthritis in the joints that link the bones in the neck,) associated stenosis (abnormal narrowing of the spinal canal,) diabetes and chronic airway obstructive disease.</p> <p>The RN SOC Assessment, dated 5/27/11, 9:26 AM to 11:14 AM, included a SN goal, "disease management." Also included as a goal was the following: "DM will be managed effectively with the SN interventions thru cert."</p> <p>The "Home Health Certification and Plan of Care," for certification period 12/02/11 to 1/30/12, included physician orders for the following safety measures: "Standard precautions, oxygen precautions, diabetic precautions, prevent falls, pulmonary/respiratory precautions, maintain safe environment, HTN (hypertension) precautions, clear pathways, assistance during ambulation/transfers, safety in ADL's and assistive devices." The "Orders for Discipline and Treatments" section of the plan of care, dated 12/02/11, also included orders to assess/teach diabetes management and assess for complications related to diabetes. Five skilled nursing visit notes, including the start of care assessment, were reviewed. Blood glucose was assessed and documented inconsistently as follows:</p> <p>RN SOC Assessment visit, dated 5/02/11 at 9:26</p>	G 158			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/19/2011
NAME OF PROVIDER OR SUPPLIER ACCESS HOME CARE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 240 WEST BURNSIDE AVENUE, SUITE B CHUBBUCK, ID 83202		
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G 158	<p>Continued From page 10</p> <p>AM - no documentation of blood glucose; RN visit, dated 12/06/11 at 9:56 AM - blood glucose was documented 86; LPN visit, dated 12/09/11 at 1:15 PM - no documentation of blood glucose; RN visit, dated 12/12/11 at 5:13 PM - no documentation of blood glucose; RN visit, dated 12/14/11 at 11:21 AM - blood glucose was documented 189.</p> <p>During three of the five visits Patient #8's blood glucose level was not assessed.</p> <p>The DON was interviewed on 12/15/11 from 10:20 AM to 10:40 AM. She reviewed Patient #8's record and confirmed there was inconsistent assessment and documentation of blood glucose levels.</p> <p>In the case of Patient #8, management of the disease process, diabetes, was incomplete and failed to follow the plan of care, as evidenced by inconsistent assessment and documentation of blood glucose levels.</p> <p>3. Patient #9 was a 93 year old male who was admitted to the agency on 12/09/11. The RN SOC assessment, dated 12/09/11, 1:41 PM to 2:48 PM, documented Patient #9 with muscle weakness and diabetes. The "Home Health Certification and Plan of Care," dated 12/09/11 and unfimed, included orders for diabetic precautions. Also included as a goal on the plan of care was the following documentation: "DM will be managed effectively with SN interventions thru cert." There was no documentation of blood glucose levels on the SOC assessment or on the visit note, dated 12/12/11, 11:53 to 12:23.</p>	G 158			

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G 158	<p>Continued From page 11</p> <p>The DON was interviewed on 12/15/11 from 10:40 AM to 10:47 AM. She reviewed Patient #9's record and confirmed there was no documentation that indicated diabetes was being assessed. She also agreed there was no documentation of blood glucose levels.</p> <p>Blood glucose levels for Patient #9 were not monitored/documented as ordered on the plan of care to assess management of diabetes.</p> <p>An agency policy titled, "CARE PLAN IMPLEMENTATION," effective 1/01/09 with no date of revision, documented the agency "provides care, treatment and/or services for each patient according to the established plan of care for treatment and/or services."</p> <p>The agency failed to ensure Patient #9's written plan of care was followed.</p> <p>4. Patient #7 was 73 year old female who was admitted to the agency on 10/20/11 for care related to Parkinson's disease, chronic obstructive pulmonary disease and congestive heart failure. The "Home Health Certification and Plan of Care," for certification period 10/20/11 to 12/18/11, included orders for continuous oxygen at 3 liters per minute via nasal cannula, skilled nursing to do a head to toe assessment every visit, vital signs every visit, and oxygen saturation levels as needed. A skilled nursing goal listed on the POC was for Patient #7 to have adequate air exchange through the certification period.</p> <p>A visit to Patient #7's residence, an ALF, was</p>	G 158		

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G 158	<p>Continued From page 12</p> <p>made on 12/14/11 between 11:00 AM and 11:50 AM to observe care provided by a PT. Patient #7 was observed, upon arrival, to be using oxygen via nasal cannula. Patient #7 was observed to remove her oxygen to ambulate with her walker in the hallways with the PT. Upon questioning, the PT stated Patient #7 used the oxygen on an as-needed basis rather than on a continuous basis. Patient #7 confirmed this information during the visit.</p> <p>Patient #7's record documented three skilled nursing visits, 10/20/11 at 2:00 PM, 10/21/11 at 12:47 PM, and 10/27/11 at 1:01 PM. The RN visits on 10/21/11 and 10/27/11 did not document whether Patient #7 was using oxygen. The RN visit on 10/27/11 did not document Patient #7's vital signs or oxygen saturation levels.</p> <p>The Director of Nursing was interviewed on 12/15/11 at 11:50 AM. She reviewed Patient #7's record and confirmed the lack of documented assessment of vital signs, oxygen use and oxygen saturation level.</p> <p>Skilled nursing did not assess vital signs and oxygen use, oxygen saturation levels consistent with the written plan of care.</p> <p>5. Patient #2 was a 79 year old female who was admitted to the agency on 5/27/11 for care after having back surgery.</p> <p>a. The RN SOC Assessment, dated 5/27/11, indicated Patient #2 had Type II diabetes. The "Home Health Certification (485)," for certification period 5/27/11 to 7/25/11 included orders for diabetic safety precautions and a goal for Patient</p>	G 158			

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G 158	<p>Continued From page 13</p> <p>#2's diabetes to be managed effectively with skilled nursing interventions through the certification period. Fifteen skilled nursing visit notes were reviewed from 5/27/11 through 6/11/11. None of the visit notes included documentation nursing staff had assessed blood glucose levels, either directly or by asking Patient #2 for a report, including the following:</p> <p>An RN SOC Assessment visit, dated 5/27/11 at 3:45 PM; RN visit, dated 5/28/11 at 10:20 AM; RN visit, dated 5/29/11 at 10:00 AM; RN visit, dated 5/30/11 at 10:45 AM; RN visit, dated 6/01/11 at 4:50 PM; RN visit, dated 6/02/11 at 2:30 PM; LPN visit, dated 6/03/11 at 1:10 PM; LPN visit, dated 6/04/11 at 10:45 AM; LPN visit, dated 6/05/11 at 11:15 AM; RN visit, dated 6/06/11 at 12:50 PM; RN visit, dated 6/07/11 at 1:25 PM; RN visit, dated 6/08/11 at 9:05 AM; RN visit, dated 6/09/11 at 2:35 PM; LPN visit, dated 6/10/11 at 1:34 PM; LPN visit, dated 6/11/11 at 9:15 AM.</p> <p>Without assessing blood sugars it would be difficult to determine if Patient #2's diabetes was being managed effectively, per the stated goal on the plan of care.</p> <p>The DON was interviewed on 12/15/11 at 11:25 AM. She reviewed Patient #2's record and confirmed there was no documentation to indicate nursing staff assessed blood sugar levels or ranges.</p> <p>Blood sugar levels for a diabetic patient were not</p>	G 158			

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G 158	Continued From page 14 assessed per written plan of care to assess diabetic management. b. Patient #2's "Home Health Certification and Plan of Care," for certification period 5/27/11 to 7/25/11, included orders for PT visits 1 time per week for 1 week, and 1-2 times per week for 6 weeks. There were no documented PT visits during the second week (week of 5/29/11). PT notes documented missed visits on 5/30/11, 6/03/11, 6/06/11, and 6/10/11. There was no documentation the physician had been notified of the missed visits. There were three documented PT visits during the 5th week (week of 6/19/11), including visits on 6/21/11, 6/22/11, and 6/23/11 instead of the 1-2 visits that were ordered. There were three documented PT visits during the 7th week (week of 7/03/11), including visits on 7/05/11, 7/07/11, and 7/08/11. Instead of the 1-2 visits that were ordered. There was no documentation to indicate orders had been obtained for the increased visit frequency. The Director of Nursing was interviewed on 12/15/11 at 11:25 AM. She reviewed Patient #2's record and confirmed there was no documentation to indicate the agency notified the physician of missed visits or obtained new orders to authorize the additional PT visits during the 5th and 7th weeks of the certification period. The PT visit schedule did not follow the written plan of care.	G 158			
G 159	484.18(a) PLAN OF CARE	G 159			

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G 159	<p>Continued From page 15</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>This STANDARD is not met as evidenced by: Based on record review, staff interview, patient interview, and observation, it was determined the agency failed to ensure the POC included all pertinent information for 1 of 13 sample patients (#7) whose records were reviewed. This had the potential to result in incomplete or uncoordinated patient care. Findings include:</p> <p>Patient #7 was 73 year old female who was admitted to the agency on 10/20/11 for care related to her Parkinson's disease, chronic obstructive pulmonary disease and congestive heart failure. The "Home Health Certification and Plan of Care," for certification period 10/20/11 to 12/18/11, included orders for continuous oxygen, a walker and a wheelchair.</p> <p>A visit to Patient #7's residence, an ALF, was made on 12/14/11 between 11:00 AM and 11:50 AM to observe care provided by a PT. The following equipment was observed in her room: a lift chair (she was sitting in it), oxygen equipment (she was using it upon arrival), a jazzy chair, a walker (she used during a walk with PT), a bath</p>	G 159	<p>G159-</p> <p>An in-service will be given to all staff regarding the use of "relevant equipment" in the home. This in-service will be given by the Director of Patient Care Services on January 18, 2012. Full compliance to this deficiency will be January 25, 2012.</p>		

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G 159	Continued From page 16 bench (located in her shower), and a toilet riser (placed on her toilet). During the visit, Patient #7 stated she used a CPAP at night.	G 159		
G 164	<p>The "Home Health Certification and Plan of Care," for certification period 10/20/11 to 12/18/11, did not include the following relevant equipment, a lift chair, oxygen equipment, a bath bench, a toilet riser, or a CPAP machine. During the visit the PT and Patient #7 confirmed she used all of the equipment.</p> <p>Patient #7's POC did not include all relevant equipment.</p> <p>484.18(b) PERIODIC REVIEW OF PLAN OF CARE</p> <p>Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on record review, observation and staff and patient interview, it was determined the agency failed to update the plan of care and alert the physician to changes in 2 of 6 patients (#3 and #7) who had home visits and whose records were reviewed. This resulted in an outdated plan of care and the potential to negatively impact patient care. Findings include:</p> <p>1. Patient #3 was an 81 year old female who lived alone and was admitted to the home health agency on 11/02/11. She was diagnosed with muscle weakness, lumbago, Alzheimer's Disease, dementia and coronary artery disease.</p>	G 164	<p>G164-</p> <p>An in-service will be given to all staff regarding policy 2030 (attached as addendum 1) coordination of services by the Director of Patient Care Services on January 18, 2012. The quality assurance nurses will do concurrent audits with weekly reports given to the Director of Patient Care Services. These reports will be discipline specific and show compliance to the plan of care. Director of Patient Care Services or delegated personnel will have a weekly interview with nurses</p>	

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G 164	<p>Continued From page 17</p> <p>The "Home Health Certification and Plan of Care," for certification period 11/02/11 to 12/31/11 included physician orders for the following recommended safety measures for Patient #3: "Standard precautions, prevent falls, cardiac precautions, maintain a safe environment, neurological precautions." Also documented in the safety measures section of the plan of care was the need for "fall precautions, hand rails, clear pathways, safety in ADL's and standard precautions."</p> <p>A "COMMUNICATION FORM" completed by the RN on 11/15/11 and timed 11:00, with no AM or PM designation, documented Patient #3 was found in the home "half dressed." The RN also documented the oven was found on, with the oven door open, and two stove top burners on and unattended. The RN documented she reported the findings and status of Patient #3 to Patient #3's son. No documentation was found that indicated the status and findings were reported to the physician or other members of the IDT.</p> <p>A home visit was conducted with Patient #3 on 12/13/11, from 12:50 PM to 1:50 PM. The home health aide was observed while assisting Patient #3 with bath and personal hygiene care. Patient #3 was observed to be very unsteady on her feet and unable to walk without assistance. To keep her safe and guard against falls, the aide held on to and guided Patient #3 when walking from one location in the apartment to another. The floors were found to be cluttered with numerous fall hazards. The fall hazards included stairs, throw rugs, clothing items, shoes, boxes, bags, small tables, decorative items and suit cases. The</p>	G 164	<p>that have worked less than 6 months with the agency and review their case load and make sure that the POC is being followed, coordination between all disciplines, and patient care needs are met. Full compliance to this regulation will be meet by January 25, 2012.</p>		

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G 164	<p>Continued From page 18</p> <p>surveyor assessed the kitchen for potential safety hazards and found a stove top burner on and unattended.</p> <p>On 12/14/11, from 12:30 PM to 12:55 PM, an interview was conducted with the RN assigned to Patient #3. The RN confirmed the safety hazards in Patient #3's home, including numerous fall hazards and burners left on by Patient #3 and unattended. She stated she did not feel the patient was safe living in the home alone. The RN also said Patient #3's impaired cognitive status was negatively impacting safety in the home. She also reviewed and confirmed the accuracy of the information documented on the 11/15/11 communication form, which stated the RN discovered the oven and stove top burners on in the home of Patient #3 and left unattended. The RN then confirmed the unsafe living conditions and changes in cognitive abilities had not been reported to the physician.</p> <p>The DON was interviewed on 12/15/11, from 10:50 AM to 11:15 AM. The safety concerns for Patient #3 were discussed. She confirmed the safety hazards and changing mental status of Patient #3 had not been reported to the physician.</p> <p>The agency failed to alert the physician of changes in the status of Patient #3.</p> <p>2. Patient #7 was 73 year old female who was admitted to the agency on 10/20/11 for care related to her Parkinson's disease, chronic obstructive pulmonary disease and congestive heart failure. The "Home Health Certification and Plan of Care," for certification period 10/20/11 to 12/18/11, included orders for</p>	G 164			

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G 164	Continued From page 19 continuous oxygen at 3 liters per minute via nasal cannula. A visit to Patient #7's residence, an ALF, was made on 12/14/11 between 11:00 AM and 11:50 AM to observe care provided by a PT. Patient #7 was observed, upon arrival, to be using oxygen via nasal cannula. She was observed to remove her oxygen to ambulate with her walker in the hallways with the PT. Upon questioning, the PT stated Patient #7 used the oxygen on an as-needed basis rather than a continuous basis. Patient #7 confirmed this information. There was no documentation the physician had been alerted to Patient #7's non-continuous use of oxygen. The Director of Nursing was interviewed on 12/15/11 at 11:50 AM. She reviewed Patient #7's record and confirmed the POC had not been updated to reflect oxygen use on an as needed basis. The agency failed to alert the physician to changes in patients that suggested a need to alter the plan of care.	G 164			
G 175	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. This STANDARD is not met as evidenced by: Based on medical record review, review of agency policies, and staff, patient, and family member interview, it was determined the agency failed to ensure the registered nurse initiated	G 175	G175- An in-service will be given to all staff regarding policy 2007 "Skilled Nursing Duties" (attached as addendum 4) by the Director of Patient Care Services on January 18, 2012. The quality assurance nurses will do concurrent audits with		

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G 175	<p>Continued From page 20</p> <p>appropriate preventative nursing interventions according to the plan of care for 1 of 6 patients (#3) who were visited in their homes. Failure to properly identify and implement necessary preventative actions resulted in negative outcomes and may have contributed to serious injury to Patient #3. Findings include:</p> <p>Patient #3 was an 81 year old female who lived alone and was admitted to the agency on 11/02/11. According to the "Home Health Certification and Plan of Care," for certification period 11/02/11 to 12/31/11, Patient #3 had diagnoses of muscle weakness, lumbago (back pain), Alzheimer's Disease, dementia and coronary artery disease.</p> <p>The RN initial visit, "SN SOC/ROC," dated 11/02/11 and timed 2:59 PM, the RN documented the following information related to Patient #3:</p> <ul style="list-style-type: none"> - impaired decision-making abilities and memory loss to the extent that supervision was required. - a history of falls, including 1-2 falls over the past 3 months. - forgetfulness and a memory deficit, including a "failure to recognize familiar persons/places, inability to recall events of the past 24 hours and significant memory loss so that supervision is required." - impaired decision-making ability and intermittent confusion in the day and evening. - reminders and assistance required from agency staff and family members when taking prescribed medications. <p>The "Home Health Certification and Plan of Care," for certification period 11/02/11 to</p>	G 175	<p>weekly reports given to the Director of Patient Care Services. These reports will be discipline specific and show compliance to the plan of care. Director of Patient Care Services or delegated personnel will have a weekly interview with nurses that have worked less than 6 months with Access Home Care and review their case load and make sure that all nursing duties are being completed. Full compliance to this regulation will be met by January 25, 2012.</p>		

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G 175	<p>Continued From page 21</p> <p>12/31/11, included physician orders for the following safety measures for Patient #3: Fall precautions, maintain a safe environment, and clear pathways.</p> <p>A "COMMUNICATION FORM" completed by the RN on 11/15/11 and timed 11:00, with no AM or PM designation, documented Patient #3 was found in the home "half dressed." The RN also documented she found the oven on, with the oven door open, and two stove top burners on and unattended. The RN documented she reported the findings to Patient #3's son. No documentation was found that indicated the status and findings were reported to the physician or other disciplines assigned to care for Patient #3.</p> <p>A home visit was conducted with Patient #3 on 12/13/11, from 12:50 PM to 1:50 PM. The home health aide was observed while assisting Patient #3 with bath and personal hygiene care, as well as light house keeping. Because Patient #3 was so unsteady when walking, the aide held to and guided her when moving through the apartment. The floors were observed to be cluttered with numerous fall hazards. The fall hazards included stairs, throw rugs, with the following items on the floor: clothing, shoes, boxes, bags, small tables, decorative items and suit cases. The surveyor assessed the kitchen for potential safety hazards and found a stove top burner on and unattended. The surveyor turned the burner off and discussed the fire hazard with Patient #3 and the home health aide. Patient #3 stated she understood the danger but did not remember turning the burner on.</p>	G 175		

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NAME OF PROVIDER OR SUPPLIER ACCESS HOME CARE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 240 WEST BURNSIDE AVENUE, SUITE B CHUBBUCK, ID 83202		
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G 175	<p>Continued From page 22</p> <p>A telephone interview was conducted on 12/14/11, from 8:50 AM to 9:00 AM, with Patient #3's son. When asked if he had been aware that his mother had left burners on, he replied he was aware and concerned and that he had counseled his mother to use a microwave instead of the burner. The son informed the surveyor Patient #3 had wandered out of doors the evening of 12/13/11, fell and fractured her hip. The plan was for Patient #3's hip to be repaired surgically and then move Patient #3 to in-patient rehabilitation, and finally to an ALF.</p> <p>The RN assigned to Patient #3 was interviewed on 12/14/11, from 12:30 PM to 12:55 PM. She confirmed there were safety concerns related to Patient #3, including fall and fire hazards. She also said Patient #3's cognitive status was impaired and unpredictable, which negatively affected safety in the home. When questioned about the information documented on the 11/15/11 communication form, which stated the oven and stove top burners were discovered on and unattended, the RN confirmed the information and, when asked, acknowledged she had not reported the incident to the physician or other disciplines assigned to care for Patient #3. When asked if she was aware of Patient #3's fall, injury, and hospitalization that occurred the evening prior, she stated Patient #3's son called her that morning and informed her. When asked if she had ever considered contacting APS, the RN stated she was hesitant to contact APS because she had a "bad experience" related to a different patient. When asked if she had initiated a social services evaluation, the RN stated she did not feel a social service evaluation was necessary because Patient #3's son assured her</p>	G 175			

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G 175	<p>Continued From page 23 his mother's needs were being met.</p> <p>The DON was interviewed on 12/15/11, from 10:50 AM to 11:15 AM. Safety hazards related to Patient #3 were discussed. When the safety hazards were discussed with the DON, she said it was the practice of the agency to assign social services to any patient who lived alone and was diagnosed with dementia or Alzheimer's disease, such as Patient #3. The DON also stated the agency was not hesitant to consult with APS when necessary. The DON confirmed the RN did not initiate the necessary preventative safety measures on behalf of Patient #3. She stated it would have been appropriate to initiate a social services referral to discuss alternative placement options due to safety concerns in the home.</p> <p>An agency policy, "PATIENT ASSESSMENT FUNCTIONS AND QUALIFICATIONS," was dated 1/01/09. It stated skilled nursing:</p> <ul style="list-style-type: none"> - Evaluates the patient in his/her place of residence for appropriateness of the care, treatment and/or services requested. - Assesses the physical, cognitive, behavioral, emotional, psychosocial and rehabilitative needs of the patient, including management of pain when appropriate. This assessment identifies facilitating factors as well as potential barriers to the achievement of patient goals. - Initiates appropriate preventive and rehabilitative nursing procedures. - Monitors patient's clinical status and coordinates care provision with other members of the 	G 175			

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G 175	Continued From page 24 healthcare team. - Prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. - Evaluates the patient's response to the plan of care. - Reassesses the patient to determine the ongoing needs for care, treatment and or services and progression toward goals. An agency policy, "STATEMENT OF POLICY," related to safety and effective 1/01/09, documented the agency promoted a safe home environment for patients, family and agency personnel. The agency did not ensure the RN initiated preventative safety measures according to the plan of care.	G 175		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on observation, staff, patient, and patient family member interview, and review of medical records and agency policies, it was determined the agency failed to ensure the RN coordinated services or informed the physician of changes in	G 176	G176- An in-service will be given to all staff regarding policy 2007 "Skilled Nursing Duties" (attached as addendum 4) by the Director of Patient Care Services on January 18, 2012. The quality assurance nurses will do concurrent audits with weekly reports given to the	

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G 176	<p>Continued From page 25</p> <p>1 of 6 patients (#3) who were visited in their homes. The agency also failed to ensure the RN informed the physician and other disciplines assigned to care for Patient #3 of changes in cognitive status that negatively impacted Patient #3's ability to live alone in a safe environment. This resulted in unsafe living conditions and may have contributed to serious injury to a patient. Findings Include:</p> <p>Patient #3 was an 81 year old female who lived alone and was admitted to the agency on 11/02/11. She was diagnosed with muscle weakness, lumbago, Alzheimer's Disease, dementia and coronary artery disease.</p> <p>The RN Initial visit, "SN SOC/ROC," dated 11/02/11 and timed 2:59 PM, the RN documented the following information related to Patient #3:</p> <ul style="list-style-type: none"> - impaired decision-making abilities and memory loss to the extent that supervision was required. - a history of falls, including 1-2 falls over the past 3 months. - forgetfulness and a memory deficit, including a "failure to recognize familiar persons/places, inability to recall events of the past 24 hours and significant memory loss so that supervision is required." - impaired decision-making ability and intermittent confusion in the day and evening. - reminders and assistance required from agency staff and family members when taking prescribed medications. <p>The "Home Health Certification and Plan of Care," for certification period 11/02/11 to 12/31/11, included physician orders for the</p>	G 176	<p>Director of Patient Care Services. These reports will be discipline specific and show compliance to the plan of care. Director of Patient Care Services or delegated personnel will have a weekly interview with nurses that have worked less than 6 months with Access Home Care and review their case load and make sure that all nursing duties are being completed. Full compliance to this regulation will be met by January 25, 2012. See also G143.</p>		

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G 176	<p>Continued From page 26</p> <p>following safety measures for Patient #3: Fall precautions, maintain a safe environment, and clear pathways.</p> <p>A "COMMUNICATION FORM" completed by the RN on 11/15/11 and timed 11:00, with no AM or PM designation, documented Patient #3 was found in the home "half dressed." The RN also documented the oven was found on, with the oven door open, and two stove top burners on and unattended. The RN documented she reported the findings to Patient #3's son. No documentation was found that indicated the status and findings were reported to the physician or other disciplines assigned to care for Patient #3.</p> <p>A home visit was conducted with Patient #3 on 12/13/11, from 12:50 PM to 1:50 PM. The floors were found to be cluttered with numerous fall hazards. The fall hazards included stairs, throw rugs, clothing items, shoes, boxes, bags, small tables, decorative items and suit cases. The surveyor assessed the kitchen for potential safety hazards and found a stove top burner on and unattended. Two shelves of a corner kitchen cabinet were also found to contain numerous bottles/containers of OTC and prescription medications, some current and some out of date. When discussed with Patient #3 during the visit, she stated her son took care of setting up her medications and giving them to her.</p> <p>A telephone interview was conducted on 12/14/11, from 8:50 AM to 9:00 AM, with Patient #3's son. When asked if he had been aware that his mother had left burners on, he replied he was aware and concerned and that he had counseled</p>	G 176			

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G 176	<p>Continued From page 27</p> <p>his mother to use a microwave instead of the burner. The son informed the surveyor Patient #3 had wandered out of doors the evening of 12/13/11, fell and fractured her hip. The plan was for Patient #3's hip to be repaired surgically and then move Patient #3 to in-patient rehabilitation, and finally to an ALF.</p> <p>On 12/14/11, from 12:30 PM to 12:55 PM, an interview was conducted with the RN assigned to Patient #3. When questioned about the information documented on the 11/15/11 communication form, which stated the oven and stove top burners were discovered on and unattended, the RN stated she did not report the findings to the physician or other disciplines assigned to care for Patient #3.</p> <p>She stated she did not feel a social services evaluation was necessary because the patient's son assured her Patient #3's needs were being met. The RN then said she was hesitant to contact APS because she had a "bad experience" related to a different patient.</p> <p>When asked about medication review and administration for Patient #3, the RN said the son took care of setting up and administering medications to Patient #3. She stated the son would ask the nurse and aide to remind Patient #3 to take her medications when/if necessary. The RN confirmed the numerous medications found in the kitchen cabinet presented a safety concern for a patient with impaired cognitive function.</p> <p>The DON was interviewed on 12/15/11, from 10:50 AM to 11:15 AM. Safety hazards related to</p>	G 176			

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G 176	<p>Continued From page 28</p> <p>Patient #3 were discussed. The DON stated she was "appalled" when she learned of the safety hazards in the home of Patient #3 and the fall and hip fracture that resulted. She said it was the practice of the agency to assign social services to any patient who lived alone and was diagnosed with dementia or Alzheimer's disease, such as Patient #3. The DON also stated the agency was not hesitant to consult with APS when necessary. The DON confirmed services were not effectively coordinated and the physician was not notified of changes in patient #3's condition or safety concerns.</p> <p>An undated agency policy "CARE PLANNING AND COORDINATION" documented the following: "The Case Manager is responsible for overseeing the care planning process to ensure that the plan is appropriate and realistic based on the patient's needs and clinical status and to promote positive outcomes, and to avoid duplication of services."</p> <p>The policy on "COORDINATION OF SERVICES," effective 1/01/09, documented the "agency promptly contacts the physician when there are changes in the patient's condition and when the agency can no longer adequately meet the Patient's medical, nursing and/or social needs in the patient's place of residence."</p> <p>An agency policy related to safety, "STATEMENT OF POLICY," dated 1/01/09, documented the agency promoted a safe home environment for patients, family and agency personnel.</p> <p>The agency did not ensure the RN effectively coordinated services for Patient #3.</p>	G 176		

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G 224	<p>484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE</p> <p>Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on record review, observation, patient interview, and staff interview, it was determined the agency failed to ensure registered nurses prepared complete written patient care instructions for home health aides for 3 of 6 patients (#2, #5 and #7) who received home health aide services whose records were reviewed. This had the potential to interfere with quality and safety of patient care. Findings include:</p> <p>1. Patient #7 was 73 year old female who was admitted to the agency on 10/20/11 for care related to her Parkinson's disease, chronic obstructive pulmonary disease and congestive heart failure. The "Home Health Certification and Plan of Care," for certification period 10/20/11 to 12/18/11, included orders for home health aide services. It also stated Patient #7 used continuous oxygen at 3 liters per nasal cannula. The tasks on the CNA Care Plan, dated 10/20/11, included bathing and toileting assistance.</p> <p>A visit to Patient #7's residence, an ALF, was made on 12/14/11 between 11:00 AM and 11:50 AM to observe care provided by a PT. The following equipment was observed in her room: a</p>	G 224	<p>G224-</p> <p>Agency recently switched their aid care plans to a new online program to allow for paperless charting. The new online program was not allowing comments to be placed for "special aid instructions." This function has been corrected through the programmers of the online company. Director of Patient Care Services will in-service case managers and aides on January 18, 2012 on these changes in how to place "special instructions" in the online program and how to access those special instruction in the online program. Quality assurance nurses will audit aid care plans upon admission for appropriate instructions on the aid care plan. Full compliance to this regulation will be meet by January 25, 2012.</p>		

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G 224	<p>Continued From page 30</p> <p>lift chair (she was sitting in it), oxygen equipment (she was using it upon arrival), a Jazzy chair, a walker, a bath bench (located in her shower), a toilet riser (placed on her toilet). The CNA Care Plan, dated 10/20/11, did not include written instructions regarding Patient #7's oxygen use, the use of the bath bench during bathing activities, or the use of a toilet riser during toileting activities.</p> <p>The DON was interviewed on 12/15/11 at 11:50 AM. She reviewed Patient #7's record and confirmed the CNA Care Plan did not specifically address oxygen use or the need for a bath bench or toilet riser.</p> <p>Written instructions for the home health aide were incomplete.</p> <p>2. Patient #5 was a 61 year old female with a diagnosis of multiple sclerosis who was admitted to the agency on 11/11/11 for care following shoulder surgery. The "Home Health Certification and Plan of Care" for certification period 11/11/11 to 1/09/12, included orders for home health aide services, a shower chair, and orders for skilled nursing to assess the surgical incision.</p> <p>A visit was made to Patient #5's home on 12/14/11 between 2:00 PM and 3:30 PM to observe care provided by an OT. A shower chair was observed to be present in the shower area.</p> <p>The task list on the CNA Care Plan, dated 11/14/11, included guidance for the home health aide to provide bathing assistance to Patient #5. The care plan did not address Patient #5's shoulder wound, whether it could get wet or</p>	G 224			

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G 224	Continued From page 31 should remain dry. It did not address the need for a shower chair, as indicated on the "Home Health Certification and Plan of Care." Written instructions for the home health aide were incomplete. 3. Patient #2 was a 79 year old female who was admitted to the agency on 5/27/11 for care after back surgery. The RN SOC Assessment, dated 5/27/11, indicated Patient #2 had Type II diabetes. The task lists for CNA Care Plans for certification period 5/27/11 to 7/25/11 and 7/26/11 to 9/23/11 included guidance for the aide to provide weekly nail care. The care plan did not inform the aide that Patient #2 was diabetic and to avoid trimming Patient #2's nails. The Director of Nursing was interviewed on 12/15/11 at 11:25 AM. She reviewed Patient #2's record and confirmed there was no clarification for the aide to avoid trimming nails. She stated it would have been alright for the home health aide to file Patient #2's nails but the agency did not allow aides to trim nails of diabetic patients. Written patient care instructions for the home health aide were incomplete.	G 224			
G 331	484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. This STANDARD is not met as evidenced by:	G 331	G331- An in-service will be given to all staff regarding policy 2007 "Skilled Nursing Duties" (attached as addendum 4) by the Director of Patient Care Services on January 18, 2012.		

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G 331	<p>Continued From page 32</p> <p>Based on record review, policy review, patient interview, and staff interview, it was determined the agency failed to ensure the initial SOC comprehensive assessment included a thorough examination of identified items of concern for 2 of 13 patients (#2 and #7) whose records were reviewed. This had the potential to lead to incomplete development of plans of care and monitoring of patient health status. Findings include:</p> <p>1. Patient #2 was a 79 year old female who was admitted to the agency on 5/27/11 for care after back surgery. The RN SOC Assessment, dated 5/27/11, indicated Patient #2 had Type II diabetes. It did not include an assessment of Patient #2's blood glucose levels or patient reports of blood glucose ranges. Baseline diabetic information is important to determine variances during the recovery process.</p> <p>The Director of Nursing was interviewed on 12/15/11 at 11:25 AM. She reviewed Patient #2's record and confirmed blood glucose levels or ranges were not assessed at SOC.</p> <p>The assessment was not complete as it was missing relevant baseline diabetic information.</p> <p>2. Patient #7 was 73 year old female who was admitted to the agency on 10/20/11 for care related to her Parkinson's disease, chronic obstructive pulmonary disease and congestive heart failure.</p> <p>A visit to Patient #7's residence, an ALF, was made on 12/14/11 between 11:00 AM and 11:50 AM to observe care provided by a PT. During the</p>	G 331	<p>This policy also includes duties upon initial nursing visit. The quality assurance nurses will do concurrent audits with weekly reports given to the Director of Patient Care Services. These reports will be discipline specific and show compliance to the plan of care. Director of Patient Care Services or delegated personnel will have a weekly interview with nurses that have worked less than 6 months with Access Home Care and review their case load and make sure that all nursing duties are being completed. Full compliance to this regulation will be met by January 25, 2012.</p>	

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

PRINTED: 01/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/19/2011
NAME OF PROVIDER OR SUPPLIER ACCESS HOME CARE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 240 WEST BURNSIDE AVENUE, SUITE B CHUBBUCK, ID 83202	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 331	Continued From page 33 visit, Patient #7 stated she used a CPAP at night and this was not new. The RN SOC Assessment, dated 10/20/11 at 1:01 PM included a section for assessment of respiratory status. A box was present to indicate use of CPAP. The box was not checked. A note was present in the respiratory section of the SOC Assessment stating Patient #7 had been diagnosed with sleep apnea. The information related to use of a CPAP was also not present on the "Home Health Certification and Plan of Care," for certification period 10/20/11 to 12/18/11.	G 331		
G 337	The assessment was not complete as it was missing relevant respiratory equipment. 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, patient interview during a home visit and staff interview, it was determined the agency failed to ensure the comprehensive assessment included a review of all medications the patient was taking for 1 of 6 patients (#5) for whom home visits were conducted. An incomplete review interfered with the ability to assess for all potential adverse effects, drug reactions, side effects or noncompliance. Findings include:	G 337	G337- An in-service will be given to all staff regarding policy 3001 "Medication Management" (attached as addendum 5) by the Director of Patient Care Services on January 18, 2012. The quality assurance nurses will do concurrent audits with weekly reports given to the Director of Patient Care Services. These reports will be discipline specific and show compliance to the plan of care including appropriate medication management. Full compliance to this regulation will be met by January 25, 2012.	

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G 337	<p>Continued From page 34</p> <p>1. Patient #5 was a 61 year old female with a diagnosis of multiple sclerosis who was admitted to the agency on 11/11/11 for care following shoulder surgery.</p> <p>A visit was made to Patient #5's home on 12/14/11 between 2:00 PM and 3:30 PM to observe care provided by an OT. At the end of the visit, Patient #5 and the surveyor reviewed her medications together, comparing them against the list on the "Home Health Certification and Plan of Care" for certification period 11/11/11 to 1/09/12. Patient #5 confirmed that all of the medications on the POC were correct. She provided a written list, dated 11/07/11, of additional medications she stated she was on, including:</p> <ul style="list-style-type: none"> - Aspirin 81 mg daily in the evening for her "heart"; - Ibuprofen as needed for "inflammation"; - Nystatin 100,000 units/gr twice daily as an "antifungal antibiotic"; - Omeprazole 40 mg daily for "esophageal spasms"; - Oxybutynin 5 mg three times per day for "incontinence"; - Triamcinolone Acetonide .50% as needed for "erythema multiforme bullous"; - Vitamin D 50,000 IU once a week for "Vitamin D deficiency." <p>When asked if she was on these medications at the start of care on 11/11/11, she stated she had been.</p> <p>The DON was interviewed on 12/15/11 at 11:45 AM. She reviewed Patient #5's record and</p>	G 337			

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G 337	Continued From page 35 confirmed the discrepancies in medications. She stated she could not explain the discrepancy. The comprehensive review did not include a review of all medications a patient was using at the time of the assessment.	G 337			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2011
NAME OF PROVIDER OR SUPPLIER ACCESS HOME CARE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 240 WEST BURNSIDE AVENUE, SUITE B CHUBBUCK, ID 83202		
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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during a recent state licensure survey of your home health agency. The surveyors conducting the survey were: Teresa Hamblin, RN, MS, HFS, Team Leader Rebecca Lara, RN, BA, HFS	N 000		
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: l. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G 143.	N 062		
N 096	03.07024. SK. NSG. SERV. N096 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: d. Initiates appropriate preventive and rehabilitative nursing procedures;	N 096		

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 JAN 30 2012
 FACILITY STANDARDS

Refer to Federal Plan of Correction G143 2/25/12

Bureau of Facility Standards

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

Brett Cooper

TITLE

Administrator

(X6) DATE

1/16/12

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OASDD1015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2011
NAME OF PROVIDER OR SUPPLIER ACCESS HOME CARE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 240 WEST BURNSIDE AVENUE, SUITE B CHUBBUCK, ID 83202		
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N 096	Continued From page 1 This Rule is not met as evidenced by: Refer to G 175.	N 096	Refer to Federal Plan of Correction G175	2/25/12
N 098	03.07024. SK. NSG. SERV. N098 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: f. Informs the physician and other personnel of changes in the patient's condition and needs; This Rule is not met as evidenced by: Refer to G 176.	N 098	Refer to Federal Plan of Correction G176	2/25/12
N 122	03.07024.SK.NSG.SERV. N122 05. Training, Assignment and Instruction of A Home Health Aide. c. Written instructions for home care, including specific exercises, are prepared by a registered nurse or therapist as appropriate. This Rule is not met as evidenced by: Refer to G 224.	N 122	Refer to Federal Plan of Correction G224	2/25/12
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be	N 152		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2011
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N 152	Continued From page 2 developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Refer to G 158.	N 152	Refer to Federal Plan of Correction G158	2/25/12
N 155	03.07030. PLAN OF CARE N155 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: c. Types of services and equipment required; This Rule is not met as evidenced by: Refer to G 159.	N 155	Refer to Federal Plan of Correction G159	2/25/12
N 172	03.07030.06.PLAN OF CARE N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This Rule is not met as evidenced by: Refer to G 164.	N 172	Refer to Federal Plan of Correction G164	2/25/12
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by	N 173		

Bureau of Facility Standards

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N 173	Continued From page 3 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 G 337.	N 173	Refer to Federal Plan of Correction G337	2/25/12



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
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January 4, 2012

Cathy Tarbet, Administrator
Access Home Care, LLC
74 West 100 North
Logan, UT 84321

Provider #137110

Dear Ms. Tarbet:

On **December 19, 2011**, a complaint survey was conducted at Access Home Care, LLC. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004965

Allegation #1: Agency staff violated patient privacy by releasing information to an Assisted Living Facility (ALF) for recruiting purposes without patient permission.

Findings #1: An unannounced visit was made to the agency 12/12/11 through 12/16/11. During the complaint investigation, surveyors reviewed grievance files, personnel files, and patient records. In addition, surveyors interviewed staff from the agency, patients during home visits, and administrative staff from an ALF.

Grievance records were reviewed from December 2009 through the time of the complaint investigation. One grievance file, dated 1/23/10, documented an allegation from a caregiver that a patient's privacy was violated when a home health aide, who was working for the agency and provided services to the patient, had disclosed information to an ALF (where she also worked) in order to recruit the patient.

The grievance record documented a partial investigation of the complaint by the Director of Nursing(DON.) She documented talking with the home health aide who denied releasing information to the Assisted Living Facility. The investigation did not document an interview

Cathy Tarbet, Administrator
January 4, 2012
Page 2 of 3

with the ALF or the patient.

The DON was interviewed on 12/13/11 at 2:00 PM. She stated the home health aide had been working only occasionally for the agency and was no longer employed by the agency. She stated as a part of the investigation into the grievance she talked to the home health aide who told her she had only given a brochure about the ALF to the patient. The home health aide denied disclosing private information to the ALF. The Administrator stated she believed what the home health aide told her and did not conduct any further investigation. She denied receiving any similar complaints regarding violation of patient privacy since the complaint received in January of 2010 through the current time.

Surveyors contacted the Administrator with the ALF named in the complaint. After being asked if they had contacted the patient, he reviewed information on his computer and stated ALF staff had contacted the patient multiple times. When asked how they obtained information to contact the patient, he said an employee of the ALF had given them contact information. The name of employee who had provided information was the same as the home health aide who had worked for the home health agency and was named in the complaint. When asked if the home health aide had been paid a bonus for making the referral, he initially said yes and then corrected the information stating the bonus incentive was not in effect at the time the employee had provided information to the ALF.

No similar grievances were present among the grievance files reviewed. Current patients were interviewed during home visits. All patients who were interviewed denied concerns regarding violations in privacy.

Personnel files of home health aides were reviewed. The file of the home health aide involved in the complaint lacked a signature acknowledging she understood the agency's privacy policy. Files of current home health aides contained evidence of training related to the obligation of staff to maintain patient privacy.

The complaint was substantiated but no deficiencies were cited. There was lack of sufficient evidence to determine any current deficient practice related to patient privacy.

Conclusion: Substantiated. No deficiencies related to the allegation are cited.

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

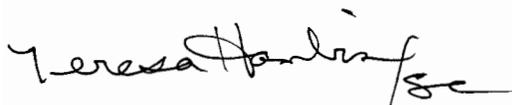
Cathy Tarbet, Administrator

January 4, 2012

Page 3 of 3

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

Sincerely,



TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srm