



IDAHO DEPARTMENT OF
HEALTH & WELFARE

G.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

February 27, 2014

Julie Hedren, Administrator
Family Home Health
1020 N Hickory Ave, Suite 100
Meridian, ID 83642-6246

RE: Family Home Health, Provider #137079

Dear Ms. Hedren:

This is to advise you of the findings of the complaint survey at Family Home Health, which was concluded on February 10, 2014.

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

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the HOME HEALTH 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 the Form CMS-2567.

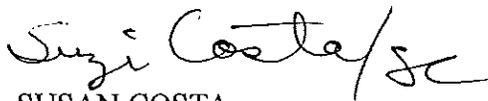
After you have completed your Plan of Correction, return the original to this office by

Julie Hedren, Administrator
February 27, 2014
Page 2 of 2

March 12, 2014, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626.

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pmt
Enclosures

No. 5123 P. 2
Mar. 28, 2014 4:50 PM Family Home Health Idaho

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:
132079

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED
02/10/14

NAME OF FACILITY
Family Home Health

STREET ADDRESS, CITY, STATE, ZIP CODE
1020 N Hickory Ave Ave, Suite 100 Meridian, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G101	484.10 Patient Rights	G101	See Plan of Correction Attached	4/1/14
G104	484.10(b)(1)&(2) Exercise of Rights and Respect for Prop	G104	See Plan of Correction Attached	4/1/14
G143	484.14(g) Coordination of Patient Services	G143	See Plan of Correction Attached	4/1/14
G145	484.14(g) Coordination of Patient Services	G145	See Plan of Correction Attached	4/1/14
G158	484.18 Acceptance of Patients, POC, Med Super	G158	See Plan of Correction Attached	4/1/14
G159	484.18(a) Plan of Care	G159	See Plan of Correction Attached	4/1/14
G164	484.18(b) Periodic Review of Plan of Care	G164	See Plan of Correction Attached	4/1/14
G236	484.48 Clinical Records	G236	See Plan of Correction Attached	4/1/14
G332	484.55(a)(1) Initial Assessment Visit	G332	See Plan of Correction Attached	4/1/14
G337	484.55(c) Drug Regimen Review	G337	See Plan of Correction Attached	4/1/14

RECEIVED
MAR 31 2014
FACILITY STANDARDS

Julie Hendren

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 reverse for further 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.

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

TITLE
Administrative

(X6) DATE
3-28-14

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2014
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NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 N HICKORY AVE, SUITE 100 MERIDIAN, ID 83642
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G 000	<p>INITIAL COMMENTS</p> <p>The following deficiency was cited during the complaint investigation survey, completed 2/05/14 - 2/10/14, at your agency. The surveyors conducting the investigation were:</p> <p>Susan Costa, RN, HFS, Team Lead Nancy Bax, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>ALF - Assisted Living Facility cm - centimeter DME - Durable Medical Equipment HHA - Home Health Aide IU - International Unit MEQ - milliequivalent mg - milligram NOMNC - Notice of Medicare Non-Coverage NS - Normal Saline OASIS - Outcome and Assessment Information Set PAC - Professional Advisory Committee POC - Plan of Care PRN - as needed PT - Physical Therapy RN - Registered Nurse SN - Skilled Nurse SOC - Start of Care tab - tablet</p>	G 000		
G 101	<p>484.10 PATIENT RIGHTS</p> <p>The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights.</p> <p>This STANDARD is not met as evidenced by:</p>	G 101		3/18/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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G 101	<p>Continued From page 1</p> <p>Based on review of patient medical records and staff interview, it was determined the agency failed to ensure patients were fully informed of their rights to appeal a discharge from home health services for 6 of 7 patients (#1, #3, #5, #6, #7 and #8) who were Medicare beneficiaries and whose records were reviewed. This had the potential for services to be terminated without the patients' understanding of their ability to appeal the discharge. Findings include:</p> <p>The CMS Manual System, Pub 100-04 includes direction to the provider that they must include the effective date (i.e. the last day of coverage) on the "Notice Of Medicare Non-Coverage" (NOMNC) form. Additionally, it states: "... the delivery of the notice should be closely tied to the impending end of coverage so a beneficiary will more likely understand and retain the information regarding the right to an expedited determination. The notice may not be routinely given at the time services begin."</p> <p>A form, titled "Notice of Medicare Non-Coverage," (NOMNC), was in each patient record. The form had been signed by the patient, but the line indicating the date it was signed was blank. The section of the form which stated "The Effective Date Coverage of Your Current Home Health Services Will End: ____," was also blank. It was unclear if each patient had received instructions of the significance of the form they had signed.</p> <p>During an interview on 2/07/14 beginning at 3:15 PM, the DCS stated he had instructed the staff to have the patient sign the NOMNC form and leave the date blank, during the initial visit when all the consents are signed. The signed form would remain at the agency office until the discharge</p>	G 101			

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G 101	<p>Continued From page 2</p> <p>date was determined. The DCS stated the form would then be completed to include the date services would end, and a date would be written in next to the patient signature (that had been signed at the date of admission) and the clinician would provide the form to the patient. He stated the clinician would explain the appeal process to the patient at that time. The clinician was to document the activity had occurred in the narrative section of their notes. He stated the signed form would be completed and provided to the patient 2 days before discharge from the agency.</p> <p>Medicare beneficiaries were not notified, at the time of discharge, of their right appeal discontinuation of home health services, as follows:</p> <p>1. The NOMNC form was not provided to the following Medicare patient before his discharge.</p> <p>a. Patient #1 was an 81 year old male, admitted to the agency on 9/06/13 for SN and PT services related to muscle atrophy, dementia, and renal failure.</p> <p>Patient #1's closed record was reviewed on 2/05/14.</p> <p>His POC for the certification period 9/06/13 to 11/04/13 included nursing visits once a week for 9 weeks, and PT for 1 visit for 1 week, and 2 visits weekly for 7 weeks.</p> <p>- A PTA visit on 10/28/13, indicated Patient #1 would be discharged on 10/30/13, but there was no documentation the NOMNC form had been provided.</p>	G 101			

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G 101	<p>Continued From page 3</p> <p>- Patient #1 was discharged from home health services on 10/30/13. Although Patient #1 was receiving SN and PT services, the physical therapist completed the agency discharge. The 10/30/13 discharge documentation included the statement that Patient #1 had met his therapy and nursing goals. No documentation was included to indicate Patient #1 received the NOMNC form, or was educated regarding his right to appeal the discharge.</p> <p>During an interview on 2/07/14 beginning at 3:15 PM, the DCS reviewed Patient #1's record and confirmed Patient #1's home health services were covered under his Medicare benefit. Additionally, the DCS verified the NOMNC form had been signed by Patient #1, it was undated, and there was no evidence a copy was completed and provided to him prior to his discharge.</p> <p>Patient #1 did not receive Notification of Medicare Non Coverage prior to his discharge.</p> <p>2. The agency required the following patients with Medicare coverage to sign the NOMNC form on admission, leaving the dates blank:</p> <p>a. Patient #3 was a 73 year old male, admitted to the agency on 7/31/13, for SN services related to wound care.</p> <p>Patient #3's record was reviewed on 2/05/14. The record included a NOMNC that was signed by Patient #3 and undated.</p> <p>During an interview on 2/7/14 at 3:15 PM the DCS reviewed Patient #3's record and confirmed the form was signed at the initial visit and the date fields were left blank. The DCS verified</p>	G 101			

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G 101	<p>Continued From page 4</p> <p>Patient #3's home health services were covered under his Medicare benefit.</p> <p>The NOMNC form signed by Patient #3 did not include the anticipated discharge date, making it invalid.</p> <p>b. Patient #5 was a 56 year old female, admitted to the agency on 1/31/14, for PT services related to sciatica.</p> <p>Patient #5's record ws reviewed on 2/06/14. The record included a NOMNC that was signed by Patient #5 and undated.</p> <p>During an interview on 2/7/14 at 3:15 pm the DCS reviewed Patient #5's record and confirmed the form was signed at the initial visit and the date fields were left blank. The DCS verified Patient #5's home health services were covered under her Medicare benefit.</p> <p>The NOMNC form signed by Patient #5 did not include the anticipated discharge date, making it invalid.</p> <p>c. Patient #8 was an 83 year old female, admitted to the agency on 4/15/13, for PT services related left leg weakness.</p> <p>Patient #8's record was reviewed on 2/06/14. The record included a NOMNC that was signed by Patient #8 and undated.</p> <p>During an interview on 2/07/14 at 3:15 PM, the DCS reviewed Patient #8's record and confirmed the form was signed at the initial visit and the date fields were left blank. The DCS verified Patient #8's home health services were covered</p>	G 101		

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G 101	<p>Continued From page 5 under her Medicare benefit.</p> <p>The NOMNC form signed by patient #8 did not include the anticipated discharge date, making it invalid.</p> <p>d. Patient #6 was an 87 year old female, admitted to the agency on 7/20/13, for SN and PT services related to late effect cardiovascular disease, depressive disorder, spinal stenosis, colostomy and Foley catheter care.</p> <p>Patient #6's record was reviewed on 2/06/14. The record included a NOMNC that was signed by Patient #6 and undated.</p> <p>During an interview on 2/07/14 beginning at 3:15 pm the DCS reviewed Patient #6's record and confirmed the form was signed at the initial visit and the date fields were left blank. The DCS verified Patient #6's home health services were covered under her Medicare benefit.</p> <p>The NOMNC form signed by patient #6 did not include the anticipated discharge date, making it invalid.</p> <p>e. Patient #7 was a 70 year old female, admitted to the agency on 6/15/13 for PT services related to backache.</p> <p>Patient #7's record was reviewed on 2/05/14. The record included a NOMNC that was signed and undated.</p> <p>During an interview on 2/07/14 at 3:15 PM, the DCS reviewed Patient #7's record and confirmed</p>	G 101			

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G 101	Continued From page 6 the form was signed at the initial visit and date fields were left blank. The DCS verified Patient #7's home health services were covered under her Medicare benefit. The NOMNC form signed by Patient #7 did not include the anticipated discharge date, making it invalid. The agency required their patients to sign the Notice of Medicare Non-Coverage form upon admission, and did not ensure it was completed and provided to the patient prior to their discharge.	G 101			
G 104	484.10(b)(1)&(2) EXERCISE OF RIGHTS AND RESPECT FOR PROP The patient has the right to exercise his or her rights as a patient of the HHA. The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent. This STANDARD is not met as evidenced by: Based on review of patient medical records and staff interview, it was determined the agency failed to protect patient rights by ensuring they were cognitively able to understand before the signing of documents and consents for 4 of 8 patients (#1, #4, #5 and #8) who lived in assisted living facilities. This resulted in the admission of vulnerable patients to the agency without a guardian or POA representation. Findings include: Included in the documents patients signed on the first visit was a form titled "Signature Agreement,"	G 104		3/18/14	

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G 104	<p>Continued From page 7</p> <p>which stated "... I have been provided a detailed explanation of the contents of each of the following forms and have been given the opportunity to ask questions regarding the home health services that I will receive... "</p> <p>1. Patient #4 was a 50 year old male, with an admission date of 1/18/14. PT services related to backache were ordered. Additional diagnoses included hypothyroidism, esophageal reflux, paranoid schizophrenia and obsessive compulsive disorder.</p> <p>The SOC admission assessment dated 1/20/14, documented Patient #4's Medical POA/Guardian was his step-sister. Additionally, the assessment of Patient #4's cognitive status indicated memory deficit and impaired decision making. The admission assessment by the PT did not document Patient #4's guardian was consulted or participated in the admission and consent process.</p> <p>Documents reviewed and signed by Patient #4 on 1/19/14 included:</p> <ul style="list-style-type: none"> - Signature Agreement, - HIPAA forms, - Patient Bill of Rights and Responsibilities, - Consents/Terms & Conditions/ Releases, - Home Safety Checklist/Fall Risk Assessment, - Patient Emergency Plan, - Patient Rights to Make Medical Treatment Decisions. <p>In an interview on 2/06/14 at 11:15 AM, the Administrator of the ALF where Patient #4 resided stated she ensured all documents were signed by his guardian. She stated the guardian was</p>	G 104			

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G 104	<p>Continued From page 8</p> <p>informed of all Patient #4's activities, including going to movie theaters.</p> <p>In an interview on 2/07/14 at 1:15 PM, the Physical Therapist who performed the admission assessment on 1/20/14, stated he did not consult with Patient #4's guardian; that he called and left a message but she did not call back. Additionally, the Physical Therapist confirmed the discrepancy of SOC dated 1/18/14 with the date Patient #4 signed the documents on 1/19/14. He stated a nurse had been scheduled to go out to see Patient #4 on 1/18/14 but actually went out on 1/19/14.</p> <p>In an interview on 2/07/14 at 1:05 PM, the DCS stated if the clinician has determined the patient is unable to sign they will stop the admission process and contact a family member or POA.</p> <p>Patient #4 was allowed to sign legal documents without his POA/guardian present, to sign also.</p> <p>2. Patient #1 was an 81 year old male, admitted to the agency on 9/06/13 for SN and PT services related to muscle atrophy, dementia, and renal failure.</p> <p>The SOC admission assessment dated 9/06/13; documented Patient #1's Medical POA was his daughter. Additionally, the assessment noted Patient #1 required supervision related to significant memory loss and impaired decision making. The admission assessment by the RN did not document Patient #1's POA was consulted or participated in the admission and consent process.</p> <p>Patient #1's record included notes from a</p>	G 104			

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G 104	<p>Continued From page 9</p> <p>physician visit dated 8/27/13. The notes stated Patient #1 was accompanied by his daughter/POA. The physician visit notes included diagnoses of dementia, memory deficit, and seizure disorder.</p> <p>Documents reviewed and signed by Patient #1 on 9/06/13 included:</p> <ul style="list-style-type: none"> - Signature Agreement, - HIPAA forms, - Patient Bill of Rights and Responsibilities, - Consents/Terms & Conditions/ Releases, - Home Safety Checklist/Fall Risk Assessment, - Patient Emergency Plan, - Medicare Secondary Payor Screen, - Notice on Therapy and Medical Supplies From Outside Sources, - Patient Rights to Make Medical Treatment Decisions. <p>The discharge assessment, completed by the Physical Therapist and dated 10/30/13, documented Patient #1 required assistance, supervision was required, and had impaired decision making.</p> <p>During an interview on 2/10/14 at 2:15 PM, the DCS reviewed Patient #1's record and confirmed the physician's diagnosis of dementia, as well as, the documentation by the therapist on the discharge assessment related to his cognitive deficits. The DCS stated if competency was in question, the POA or guardian would be included in the consent signing process.</p> <p>Patient #1 was allowed to sign legal documents without his POA present, to sign also.</p>	G 104			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/10/2014
NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 N HICKORY AVE, SUITE 100 MERIDIAN, ID 83642		
(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 104	<p>Continued From page 10</p> <p>3. Patient #5 was a 56 year old female, admitted to the agency on 1/31/14 for PT services related to sciatica and low back pain. Additional diagnoses included paranoid schizophrenia, and depression.</p> <p>The SOC admission assessment dated 1/31/14, documented Patient #5 required supervision related to disruptive and socially inappropriate behavior, delusional, hallucinatory and paranoid behavior, impaired decision making, and was unsafe due to cognitive and psychiatric impairments. The admission assessment by the Physical Therapist did not document if Patient #5 had a designated POA or guardian, or if one was consulted or participated in the admission and consent process.</p> <p>Documents reviewed and signed by Patient #5 on 1/31/14 included:</p> <ul style="list-style-type: none"> - Signature Agreement, - HIPAA forms, - Patient Bill of Rights and Responsibilities, - Consents/Terms & Conditions/ Releases, - Home Safety Checklist/Fall Risk Assessment, - Patient Emergency Plan, - Medicare Secondary Payor Screen, - Notice on Therapy and Medical Supplies From Outside Sources, - Patient Rights to Make Medical Treatment Decisions. <p>Patient #5's record indicated she had attempted to cancel home health services the two days following her consent to start the care. The agency failed to ensure Patient #5 was allowed to exercise her right to refuse treatment and cancel home health services, due to her impaired mental</p>	G 104			

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G 104	<p>Continued From page 11</p> <p>status, although the agency allowed her to consent for treatment without her mental status being questioned. The documentation is as follows:</p> <p>A "COMMUNICATION NOTE," dated 2/02/14 at 5:30 PM, stated the Physical Therapist spoke with a staff member at the ALF regarding Patient #5's phone calls to cancel home health services. The staff member stated Patient #5 had been difficult to redirect related to her schizophrenia and other factors. The therapist stated the ALF staff had felt PT was necessary and that Patient #5 was having a difficult day.</p> <p>A "COMMUNICATION NOTE," written by the weekend shift RN, dated 2/03/14, stated Patient #5 had contacted the agency on 2/01/14 and 2/02/14 to cancel home health services. The note stated the Physical Therapist was notified.</p> <p>A "MISSED VISIT," note dated 2/03/14, documented "Patient [#5] refused care. CG (caregiver) attempted to help patient realize importance of PT. MD's RN contacted in person. Will attempt to see patient on 2/5 and 2/7."</p> <p>A "COMMUNICATION NOTE," dated 2/03/14, the therapist documented when he arrived for the therapy appointment, Patient #5 refused treatment. The note further stated the therapist went to Patient #5's physician's office and spoke with the nurse and explained "the situation." The therapist wrote the RN advised him to continue with visits as Patient #5 frequently changes her mind.</p> <p>A "MISSED VISIT," dated 2/05/14, documented Patient #5 refused treatment, and the</p>	G 104			

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G 104	<p>Continued From page 12</p> <p>appointment was cancelled due to patient request.</p> <p>A "PHYSICIAN ORDER," request form, signed and dated by the therapist on 2/05/14, and unsigned by the physician, stated Patient #5 continued to refuse care. The form stated another attempt to see her would be planned for 2/07/14. The form further stated "May DC (discharge) from services secondary to refusal of care resulting from exacerbation of impaired mental status."</p> <p>During an interview on 2/07/14 beginning at 1:30 PM, the Physical Therapist reviewed Patient #5's record and confirmed her attempts to cancel home health services and her refusal of treatment on 2/03/14 and 2/05/14. The therapist stated Patient #5's son was her POA, and the ALF was going to contact him regarding her desire to cancel home health services. The therapist confirmed that patients have the right to refuse treatment and cancel services. He confirmed that Patient #5 had signed her consents, and therefore should have been able to cancel home health services. The therapist stated Patient #5 was scheduled for a visit that day and would probably be discharged if she refused therapy.</p> <p>Patient #5's admission assessment, noted above, identified impaired decision-making abilities, however, her POA was not involved in the admission process. Patient #5 was allowed to sign admission documents and consents without the involvement of her POA, however, she was not allowed to exercise her rights to refuse treatment and cancel home health services. Agency staff were inconsistent in the rights afforded to Patient #5.</p>	G 104			

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G 104	<p>Continued From page 13</p> <p>4. Patient #8 was an 83 year old female admitted to the agency on 4/15/13 for PT services related to left leg weakness.</p> <p>The initial assessment dated 4/15/13, documented Patient #8 had a recent decline in her mental, emotional, and behavioral status and had cognitive and psychiatric impairments. Additionally, Patient #8 was documented as requiring supervision related to significant memory loss and memory deficit. The admission assessment by the Physical Therapist stated Patient #8 had a Medical POA but did not document if that individual had been consulted or participated in the admission and consent process.</p> <p>Documents reviewed and signed by Patient #8 on 4/15/13 included:</p> <ul style="list-style-type: none"> - Signature Agreement, - HIPAA forms, - Patient Bill of Rights and Responsibilities, - Consents/Terms & Conditions/ Releases, - Home Safety Checklist/Fall Risk Assessment, - Patient Emergency Plan, - Patient Rights to Make Medical Treatment Decisions. <p>A PTA visit was documented on 4/17/13.</p> <p>An OASIS-C "DISCHARGE FROM AGENCY," dated 4/18/13, documented "Patient and family wanted to discharge from services secondary to desiring HH (Home Health) PT from another agency."</p> <p>A patient discharge note was sent to the</p>	G 104		
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G 104	Continued From page 14 physician on 6/11/13, which read "No change to functional mobility. Patient and family wanted to have services provided by another HHA." The note was signed by Patient #8's physician 6/11/13 and faxed to the agency the same day, which was 2 months after she had elected to change to another agency. During an interview on 2/10/14 beginning at 1:40 PM, the Physical Therapist who conducted the admission assessment reviewed Patient #8's record and confirmed the documentation of impaired cognition. The therapist stated Patient #8's family had contacted him and stated they wanted to change to another agency. He confirmed the consents and other documents were signed by Patient #8 and not the POA.	G 104			
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 staff interview, and review of patient records, it was determined the agency failed to ensure care coordination between disciplines was documented for 1 of 8 patients (#2) who received services from more than one discipline and whose records were reviewed. This interfered with quality and continuity of patient care.	G 143		3/18/14	

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G 143	Continued From page 15 Findings include: 1. Patient #2 was a 62 year old male, admitted to the agency on 12/12/13 for PT services related to late effect of hemiplegia, muscle weakness and depressive disorder. After identification of Patient #2's need for wound care, SN services were ordered on 12/19/13. Patient #2's record documented he complained of a stomach illness to the therapist on 12/19/13, 12/24/13, 12/26/13 and 12/31/13. There was no documentation his illness was reported to the RN Case Manager, the physician, or the ALF staff. During an interview on 2/07/14 at 2:30 PM, the Physical Therapist confirmed that he did not communicate the Patient #2's complaints to the RN, physician, or ALF staff. The agency did not ensure communication with all members of Patient #2's health care team occurred.	G 143		
G 145	484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure a written summary report was sent to the attending physician at least every 60 days for 2 of 2 patients (#3 and #6) who had received home health services for more than 1 certification	G 145		3/18/14

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G 145	<p>Continued From page 16</p> <p>period and whose records were reviewed. This had the potential to result in decreased physician awareness of patient conditions and reduce the quality of patient care. Findings include:</p> <p>1. Patient #3 was a 73 year old male, admitted to the agency on 7/31/13, after a hospital discharge following a surgical procedure to remove a cancerous lesion from his chest.</p> <p>a. A recertification assessment for Patient #3's second certification period, from 9/29/13 through 11/27/13, was performed on 9/27/13. His record did not include documentation a 60 day summary was provided to his physician.</p> <p>b. A recertification assessment for Patient #3's fourth certification period from, 1/27/14 to 3/27/14, was performed on 1/24/14. His record did not include documentation a 60 day summary was provided to his physician.</p> <p>During an interview on 2/07/14 beginning at 3:15 PM, the DCS reviewed Patient #3's record and confirmed that two 60 day summaries were not sent to his physician.</p> <p>The agency did not ensure Patient #3's physician was provided summaries of his progress during the certification periods.</p> <p>2. Patient #6 was an 87 year old female, admitted to the agency on 7/20/13, for SN and PT services related to late effect cardiovascular disease, depressive disorder, spinal stenosis, colostomy and foley catheter care.</p> <p>A recertification assessment was performed on 9/17/13. Her record did not include a 60 Day</p>	G 145		
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G 145	Continued From page 17 Summary for the certification period of 7/20/13 to 9/17/13. There was no evidence a 60 Day Summary had been provided to Patient #6's physician. In an interview on 2/07/14 at 4:00 PM, the DCS reviewed Patient #6's record and stated the 60 Day Summary was created, but was not completed or sent to the patient's physician. The agency did not ensure Patient #6's physician was provided a summary of her progress during the certification period.	G 145		
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 review of patient records and staff interview, it was determined the agency failed to ensure care followed a physician's written POC for 5 of 8 patients (#2, #3, #5, #6 and #8,) whose records were reviewed. This resulted in nursing and therapy visits performed without physician orders and services not provided consistent with physician orders. This had the potential to result in negative patient outcomes. Findings include: 1. Patient #2 was a 62 year old male admitted on 12/12/13, for physical therapy services related to late effect hemiplegia, muscle weakness and depressive disorder. a. The POC signed by the physician for the	G 158		3/18/14

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G 158	<p>Continued From page 18</p> <p>certification period of 12/12/13 to 2/09/13, included orders for PT 1 time a week for 1 week and 2 times a week for 6 weeks. However, Patient #2's record documented only 1 visit during week 4 of the certification period, completed on 12/31/13. Two PT visits were ordered for week 4 of the certification period, 1 visit was done.</p> <p>Patient #2's record did not include documentation the physician was notified of the missed visit.</p> <p>In an interview on 2/10/14 at 3:00 PM the DCS reviewed Patient #2's record and confirmed only one visit was completed and the physician was not notified of the missed visit.</p> <p>The agency did not ensure Patient #2 received PT services as ordered in his POC.</p> <p>b. On 12/20/13, physician orders were obtained for Patient #2 for skilled nurse visits. On 1/14/14 a new physician's order was obtained for skilled nurse visits 2 times a week for 4 weeks plus 2 PRN visits.</p> <p>Patient #2's POC included 2 pm visits, however, it did not include a description of the patient's medical signs and/or symptoms that would require a PRN visit. This allowed for nursing staff to determine when a PRN visit may be needed, instead of completing a PRN visits as ordered by the physician.</p> <p>In an interview on 2/10/14 at 3:00 PM, the DCS reviewed Patient #2's record and confirmed the order did not contain a description of the patient's medical signs and/or symptoms that would require a PRN visit.</p>	G 158		

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G 158	<p>Continued From page 19</p> <p>The agency failed to ensure Patient #2's PRN visits followed a POC established by the physician.</p> <p>c. On 12/20/13, physician orders were obtained for Patient #2 for skilled nurse visits 2 times a week for 4 weeks, 1 time a week for 1 week, 0 times a week for 1 week, 1 time a week for 1 week, 0 times a week for 1 week, and 1 time a week for 1 week. On 1/14/14 a new physician's order was obtained for skilled nurse visits 2 times a week for 4 weeks plus 2 PRN visits. Patient #2's SN visits were not performed according to the frequency ordered, as follows:</p> <ul style="list-style-type: none"> - 2 skilled nurse visits were ordered for week 3 of the certification period. 1 visit on 12/23/13, was documented. - 2 skilled nurse visits were ordered for week 4 of the certification period. 1 visit on 12/30/13 was documented. - 2 skilled nurse visits were ordered for week 6 of the certification period. 1 visit on 1/14/14 was documented. -2 skilled nurse visits were ordered for week 7 of the certification period. 1 visit on 1/21/14 was documented. <p>In an interview on 2/10/14 at 3:00 PM the DCS reviewed the Patient #2's record and confirmed the missed visits. The DCS also confirmed Patient #2's physician was not notified of the missed visits.</p> <p>The agency did not ensure Patient #2 received SN services at the frequency ordered by the</p>	G 158			

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G 158	<p>Continued From page 20 physician.</p> <p>2. Patient #6 was an 87 year old female, admitted to the agency on 7/20/13, for SN and PT services related to late effect cardiovascular disease, depressive disorder, spinal stenosis, colostomy and foley catheter care.</p> <p>a. Patient #6's POC for certification period 7/20/13 to 9/17/13, did not include orders for HHA visits. An order request to Patient #6's physician was dated 7/24/13. The order request did not include a physician signature or indicate a verbal order was obtained.</p> <p>Patient #6's record included HHA visit notes dated 7/23/13, 7/25/13, 8/26/13, 8/29/13, and 9/09/13.</p> <p>During an interview on 2/10/14 at 3:00 PM the DCS reviewed Patient #6's record and confirmed the request to the physician for orders for HHA services was not signed. He stated upon performing a chart audit, the agency determined orders for the HHA services were not present in Patient #6's record. He stated he initiated the order request to the physician on 9/17/13. He confirmed the date of the order request (7/24/13) was back dated and not accurate.</p> <p>HHA services were provided to Patient #6 without a physician's order.</p> <p>b. Patient #6's POC for the certification period of 9/18/13 to 11/16/13, included orders for 2 PRN SN visits, in addition to, the ordered visits. However, the POC did not include a description of Patient #6's medical signs and/or symptoms that would require PRN visits.</p>	G 158		
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G 158	Continued From page 21 In an interview on 2/10/14 at 3:00 PM the DCS reviewed Patient #6's record and confirmed the need for PRN visits was not specified on the POC. Patient #6's POC did not provide specific direction as indicate why PRN nursing visits would be needed. c. Patient #6's POC for the certification period 9/18/13 to 11/17/13, included an order for 1 SN visit the first week of the certification period. No SN visits were documented for that week and there was no documentation of a missed visit note to the physician. During an interview on 2/07/14 at 3:15 PM the DCS reviewed Patient #6's chart and confirmed the missed visit on week 1 and that her physician had not been notified of the missed visit. Patient #6's care did not follow her POC. 3. Patient #3 was a 73 year old male, admitted to the agency on 7/31/13, after a hospital discharge following a surgical procedure to remove a cancerous lesion from his chest. Patient #3's POC for the certification 7/31/13 through 9/27/13, included wound vac dressing changes 3 times a week. On 8/21/13, the nursing notes documented his wound vac was discontinued, and he was to receive SN visits twice daily for wet to dry dressing changes. Physician verbal orders were not noted. The record included physician signed and faxed orders on 8/27/13 for BID dressing changes. Nursing services provided to Patient #3 were not consistent with the physician	G 158			

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G 158	<p>Continued From page 22 ordered POC as follows:</p> <p>a. Dressing changes were performed twice a day on 8/22/13, 8/23/13, 8/24/13, 8/25/13, and 8/27/13, before physician orders were obtained on 8/27/13.</p> <p>b. Dressing changes were not as the physician ordered. Patient #3's record included verbal orders dated 9/04/13, for the following dressing change routine. "Patient to do own dressing changes BID with Home Health Nursing 1 time a week. Cleanse with Wound Cleanser and 3X3 gauze [sic]. Cover wound with folded 3X3 gauze, wet with NS. Cover wet gauze with dry 3X3 gauze and secure with paper tape."</p> <p>- 9/04/13, the nurse narrative of the dressing change: "Removed old dressing. Cleansed with NS and 3X3 gauze. Paper tape applied." The nurse did not use wound cleanser, or cover the wound with NS soaked gauze. The nurse did not document covering the wound with dry 3X3.</p> <p>- 9/05/13, the nurse narrative of the dressing change: "Removed old dressing. Cleansed with NS and 3X3 gauze. Paper tape applied." The nurse did not document she used wound cleanser, or cover the wound with NS soaked gauze. The nurse did not document covering the wound with dry 3X3. Additionally, Patient #3's record did not indicate why a visit was performed after 1 day, when weekly visits were ordered on 9/04/13.</p> <p>- 9/13/13, the nurse narrative of the dressing change: "Removed old dressing. Cleansed with NS and 3X3 gauze. Paper tape applied." The nurse did not document she used wound</p>	G 158			

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G 158	<p>Continued From page 23</p> <p>cleanser, or cover the wound with NS soaked gauze.</p> <p>- 9/20/13, the nurse narrative of the dressing change: "...Cleansed with NS and 3X3 gauze. Applied skin prep to peri wound. Applied 1 folded 3X3 to wound bed covered wound with 2 pieces dry gauze." The nurse did not document she used wound cleanser, she applied skin prep although it was not ordered, and did not apply NS to the gauze.</p> <p>b. A recertification assessment for Patient #3's second certification period was dated 9/27/13. In the assessment "Coordination of Care" section, the box next to "MD" was marked, indicating his physician had been contacted. The name of the physician was not specified by the nurse who completed the recertification. There was no narrative or further documentation on the recertification assessment to indicate Patient #3's physician had agreed he needed further skilled nursing visits. A verbal order for further SN visits was not found in Patient #3's medical record.</p> <p>Patient #3's POC for the second certification period, 9/29/13 through 11/27/13, was not signed by a physician. The physician listed on the POC was different than the physician listed on his previous POC's.</p> <p>Nursing notes during the prior certification period were reviewed for an indication Patient #3 had changed physicians or had more than 1 physician involved with his care. There was no documentation of a change of physician.</p> <p>During an interview on 2/07/14 beginning at 3:15 PM, the DCS stated that during Patient #3's initial</p>	G 158		
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G 158	<p>Continued From page 24</p> <p>certification period his physician had stopped providing medical oversight, and the nurse providing his wound care visits had not been diligent with documentation of such. The DCS confirmed the agency was unable to secure a physician signature which would authorize services included on Patient #3's POC for the certification period of 9/29/13 through 11/27/13. The DCS confirmed he was the nurse who had completed Patient #3's recertification assessment, and stated he did not communicate with a physician regarding the continuation of home health services although he had marked he had done so.</p> <p>Patient #3's record included SN visit notes dated 10/02/13, 10/11/13, 10/25/13, 11/01/13, 11/08/13, 11/12/13, 11/15/13, 11/22/13, and 11/27/13. The SN visits were not authorized by a physician.</p> <p>Patient #3 received 9 SN visits without a physician's order.</p> <p>d. A recertification assessment for Patient #3's third certification period, was dated 11/27/13. In the assessment "Coordination of Care" section, the box next to "MD" was marked, indicating Patient #3's physician had been contacted. The nurse who performed the assessment documented she spoke with "Dr. (name)". The nurse documented Patient #3 would require continued wound care and increased frequency of SN visits to twice weekly for 4 weeks. The POC for the certification period 11/28/13 to 1/26/14, was signed by a physician on 12/18/13. This physician differed from the one the nurse documented receiving orders from on 11/27/13, at the time of the racertification assessment.</p>	G 158			

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G 158	<p>Continued From page 25</p> <p>During an interview on 2/07/14 beginning at 3:15 PM, the DCS reviewed Patient #3's record and stated the individual who was named as physician on the recertification was, in fact, a Nurse Practitioner. The DCS stated although Patient #3 was receiving care from 4 physicians, none wanted to sign his POC to certify his need of home health services. He stated the Medical Director for the agency was notified and signed the POC for the certification period 11/28/13 through 1/26/14, to cover the episode until Patient #3 was able to secure a physician.</p> <p>Patient #3's medical record included SN visit notes dated 12/03/13, 12/06/13, 12/10/13, and 12/13/13. These visits were provided under a POC authorized by a nurse practitioner, not a physician, as required.</p> <p>4. Patient #5 was a 56 year old female admitted to the agency on 1/31/14 for PT services related to sciatica.</p> <p>The SOC comprehensive assessment, dated 1/31/13, was performed by the physical therapist. In the section "Coordination of Care," the box next to "MD" was marked, indicating Patient #5's physician had been contacted. There was no narrative to indicate which physician was notified, what was discussed, or if orders were received.</p> <p>A physician order request dated 1/31/14, initiated by Patient #5's physical therapist, informed the physician a PT evaluation had been completed. The request included "PT clarification orders beginning 1/31/14, 1w1, 2w3." The order request was not signed by Patient #5's physician, nor were verbal orders found in her medical record.</p>	G 158			

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G 158	<p>Continued From page 26</p> <p>Patient #5's record indicated therapy services were attempted on 2/03/14 and 2/05/14, however, Patient #5 refused the visits.</p> <p>During an interview on 2/07/14, beginning at 3:15 PM, the DCS reviewed Patient #5's record and confirmed orders for therapy services had not been signed by her physician.</p> <p>Two PT visits for Patient #5 were initiated without physician authorization.</p> <p>5. Patient #8 was an 83 year old female admitted to the agency on 4/15/13 for PT services related to lower back pain. A SOC comprehensive assessment, dated 4/15/13, was performed by the physical therapist. In the section "Coordination of Care," the box next to "MD" was marked, indicating Patient #8's physician had been contacted. There was no narrative to indicate which physician was notified, what was discussed, or if orders were received.</p> <p>Patient #8's record indicated she had 1 PTA visit on 4/17/13, then on 4/18/13, she and her family canceled home health services.</p> <p>The development of Patient #8's POC was completed and signed by the therapist on 4/21/13. The POC for Patient #8 was signed by her physician on 4/23/13. Patient #8 received a PTA visit on 4/17/13, before the physician approved the POC on 4/23/13.</p> <p>During an interview on 2/07/14 beginning at 1:40 PM, the therapist who admitted Patient #8 to the agency reviewed her record and confirmed the POC was completed and sent to the physician for review after she had been discharged.</p>	G 158		

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G 159	<p>The agency did not ensure patient care followed the physician POC.</p> <p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure the plan of care included all, and only, pertinent information, for 2 of 8 patients (#1 and #2) whose records were reviewed. This had the potential to interfere with continuity and completeness of patient care. Findings include:</p> <p>1. Patient #2 was a 62 year old male admitted on 12/12/13, for physical therapy services related to late effect hemiplegia, muscle weakness and depressive disorder.</p> <p>Patient #2 received 11 PT visits between 12/13/13 and 1/21/14, in which the therapist documented therapeutic exercise, bed mobility training, transfer training and the establishment of a home exercise program. Patient #2's POC for the certification period 12/12/13 to 2/09/14, did not include orders for the interventions that the</p>	G 159		3/18/14	

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G 159	<p>Continued From page 28</p> <p>therapist documented during those visits. The PT POC, completed by the physical therapist on 12/13/13, was reviewed. It was not signed by the physician, nor was a verbal order for the PT POC found in Patient #2's medical record.</p> <p>In an interview on 2/07/14 at 2:30 PM, the physical therapist stated the treatment plan with specific interventions was included on the PT POC. He confirmed Patient #2's POC for the certification period of 12/12/13 to 2/09/14, did not contain the PT treatments noted above. He stated the electronic medical record was supposed to allow the treatments identified on the PT POC to populate the POC, but that had not happened in this case. The therapist confirmed he had not contacted the physician to obtain verbal orders.</p> <p>Patient #2's POC did not contain all PT treatments provided to him.</p> <p>2. Patient #1 was an 81 year old male admitted to the agency on 9/06/13 for SN and PT services related to muscle atrophy and abnormal gait. Additional diagnoses included HTN, renal failure, dementia, cardiomyopathy, seizure disorder, and Type II DM. Patient #1's medical record, including his POC, for the certification period 9/06/13 through 11/04/13, was reviewed. The POC included the following discrepancies:</p> <p>a. Patient #1's POC, section 17, (Allergies) stated "NKA," indicating Patient #1 had No Known Allergies. The SOC comprehensive assessment, dated 9/06/13, indicated Patient #1 had a significant allergy to Penicillin, which caused an anaphylaxis response. During an interview on 2/07/14 beginning at 3:15 PM, the DCS reviewed</p>	G 159			

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G 159	<p>Continued From page 29</p> <p>Patient #1's record and confirmed the POC did not include Patient #1's allergy to Penicillin, as identified on the comprehensive assessment. He stated the allergy information did not transfer automatically on to the POC; it needed to be entered separately.</p> <p>b. Patient #1's POC included orders for the SN to assist him with obtaining an ERS (Emergency Response System) button, the importance of receiving influenza and pneumococcal vaccines, and safety measures such as removing clutter from patient's path. During an interview on 2/07/14 beginning at 3:15 PM, the DCS reviewed Patient #1's record and confirmed the POC did not accurately reflect Patient #1's needs. The DCS stated Patient #1 lived in an ALF, and the orders to assist him in obtaining an ERS button, as well as, the influenza vaccine, were not appropriate to go on his POC. He stated the nurse had entered those items in error.</p> <p>c. Patient #1's POC, section 14, (DME and Supplies) was blank and did not include DME items that were identified during the comprehensive assessment, performed 9/06/13:</p> <ul style="list-style-type: none"> - Elevated Toilet Seat, - Tub/Shower Bench, - Grab Bars, - Walker, - Wheelchair. <p>During an interview on 2/07/14 beginning at 3:15 PM, the DCS reviewed Patient #1's record and confirmed the DME items noted in the comprehensive assessment were not included on the POC.</p>	G 159			

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G 159	Continued From page 30 d. Patient #1's POC did not include compression stockings, which were identified in the comprehensive assessment, dated 9/06/13, as being used. During an interview on 2/07/14 beginning at 3:15 PM, the DCS reviewed Patient #1's record and confirmed the compression stockings noted in the comprehensive assessment were not included on the POC. e. Patient #1's POC did not include pain medications, and his comprehensive assessment indicated his pain level at 2. The POC included SN orders for his instruction of nonpharmacologic pain relief measures. For goals, the POC stated Patient #1 would be able to list 2 of 3 side effects of pain medications within 60 days. Additionally, the goals stated Patient #1 would be able to list 1 of 2 uses of pain medication within 60 days. The comprehensive assessment indicated Patient #1 was cognitively impaired, and the stated goals were therefore unrealistic, as well as, unnecessary as he was not noted as taking pain medications. During an interview on 2/07/14 beginning at 3:15 PM, the DCS reviewed Patient #1's record and confirmed the interventions and teaching of Patient #1 related to pain management were unrealistic goals with his dementia diagnosis, and the fact he resided in an ALF.	G 159			
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the	G 164		3/18/14	

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G 164	<p>Continued From page 31</p> <p>physician to any changes that suggest a need to alter the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the physician was notified of changes in patient status that may indicate a need to alter the POC for 2 of 8 patients (#2 and #3) whose records were reviewed. The had the potential to result in the provision of inappropriate care and services. The findings include:</p> <p>1. Patient #3 was a 73 year old male, admitted to the agency on 7/31/13 after a hospital discharge following a surgical procedure to remove a cancerous lesion from his chest. Patient #3's POC for the certification period 7/31/13 through 9/27/13, included discharge goals of "Patient to be discharged when wound healed." SN visits for wound vac and wound care were ordered.</p> <p>Patient #3's POC for the second certification period of 9/28/13 through 11/27/13, also included discharge goals of "Patient to be discharged when wound is healed." The orders included SN visits once weekly for 8 weeks. The POC stated Patient #3 would change his own dressing daily.</p> <p>Patient #3 started radiation therapy to his chest on 10/03/13.</p> <p>A "SKILLED NURSE PROGRESS NOTE," dated 10/11/13, documented "Patient [#3] doing a good job of changing his own dressing. Wound is healing very well, but Radiation burn to site is very painful." The nursing note did not indicate the nurse performed a skilled visit, and the nurse</p>	G 164			

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G 164	<p>Continued From page 32</p> <p>did not document communication with the physician anticipating discharge from nursing care.</p> <p>A "SKILLED NURSE PROGRESS NOTE," dated 10/25/13, documented "Wound is no longer open. Patient is applying cream with Lidocaine to help relieve the pain from the burn of daily Radiation tx." The nurse noted in the narrative: "No medication changes. Wound is healed closed, but Radiation burn is present." The note contained the plan of Patient #3's discharge when his wound was healed. There was no documentation to indicate the nurse notified the physician that Patient #3's wound was healed.</p> <p>A "SKILLED NURSE PROGRESS NOTE," dated 11/01/13, documented "Wound is no longer open. Patient has first degree radiation burn covering his chest. HH will continue to monitor for duration of radiation therapy for changes in skin condition." The note contained the same plan of Patient #3's discharge when his wound was healed. The RN did not document communication with the physician regarding the continuation of nursing visits to monitor Patient #3 throughout the duration of radiation therapy, since his wound was healed.</p> <p>A "SKILLED NURSE PROGRESS NOTE," dated 11/08/13, documented "Wound is no longer open. Radiation burn present." The note contained the plan of Patient #3's discharge when his wound was healed. There was no documentation the physician was informed that Patient #3's wound was healed. Additionally, there was no documented communication with the physician regarding the continuation of nursing visits to monitor Patient #3 throughout the duration of</p>	G 164		
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G 164	<p>Continued From page 33 radiation therapy.</p> <p>A "SKILLED NURSE PROGRESS NOTE," dated 11/15/13, documented "Original wound on chest is healed." The note contained the plan of Patient #3's discharge when his wound was healed. The RN documented she communicated with the ALF staff regarding Patient #3's status. There was no documentation the physician was notified Patient #3's wound was healed and SN goals met.</p> <p>A "SKILLED NURSE PROGRESS NOTE," dated 11/22/13, documented "Original wound on chest is healed." The note contained the plan of Patient #3's discharge when his wound was healed. The RN did not document communication with the physician regarding the continuation of nursing visits to monitor Patient #3 throughout the duration of radiation therapy or to indicate the wound was healed.</p> <p>Patient #3's POC for certification period 11/28/13 to 1/26/14, included SN orders for dressing changes 2 times a week for 4 weeks, and 1 time weekly for 5 weeks. The POC documented Patient #3 would perform his own wound dressing changes all other days. A discharge goal included "Wound(s) will heal without complication by the end of the episode." The discharge plans included "When goals are met."</p> <p>Nursing notes from 12/10/13 through 1/26/14, documented Patient #3's wounds were healed. Patient #3 continued to reside in the ALF, and communication was documented between the RN and ALF staff. There was no documentation the physician was contacted to consider SN services be discontinued related to Patient #3's improved condition.</p>	G 164			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2014
NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 N HICKORY AVE, SUITE 100 MERIDIAN, ID 83642	
(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 164	<p>Continued From page 34</p> <p>During an interview on 2/07/13 beginning at 3:15 PM, the DCS reviewed Patient #3's record and confirmed the physician was not notified that Patient #3's SN goals had been met.</p> <p>Patient #3's physician was not informed that Patient ##3's nursing goals had been achieved.</p> <p>2. Patient #8 was an 83 year old female admitted to the agency on 4/15/13, for PT services related to lower back pain.</p> <p>Patient #8's record indicated she had 1 PTA visit on 4/17/13, then on 4/18/13, she and her family canceled home health services. A physical therapist completed a "DISCHARGE FROM AGENCY" assessment for Patient #8, on 4/18/13</p> <p>The same physical therapist who completed the discharge assessment, developed and signed Patient #8's POC on 4/21/13, 3 days after her discharge. The POC was sent to the physician. The POC for Patient #8 was signed by her physician on 4/23/13. There was no documentation the physician was notified of Patient #8's discharge at that time.</p> <p>A form, titled "PT DISCHARGE", completed by the same physical therapist, was faxed to the physician on 6/11/13, and signed by the physician and returned on the same date. There was no documentation Patient #3's physician was notified of her discharge prior to 6/11/13.</p> <p>During an interview on 2/07/14 beginning at 1:40 PM, the physical therapist referenced above, confirmed the physician was not notified of her discharge until 6/11/13 when the discharge notice</p>	G 164		

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G 164	Continued From page 35 was signed and returned to the agency.	G 164			
G 236	<p>Patient #8's physician was not notified of changes that altered her plan of care.</p> <p>484.48 CLINICAL RECORDS</p> <p>A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.</p> <p>This STANDARD is not met as evidenced by: Based on record review, policy review and staff interview, it was determined the agency failed to ensure complete and accurate documentation for 3 of 8 patients (#2, #4, and #6), whose records were reviewed. This had the potential result in inconsistent and incomplete care provided to patients. Findings include:</p> <p>1. Patient #2 was a 62 year old male admitted on 12/12/13, for PT services related to late effect hemiplegia, muscle weakness and depressive disorder.</p> <p>An Agency policy titled "WOUND MANAGEMENT," undated, included: "The Registered Nurse or Licensed Therapist performs a comprehensive wound assessment: -During the initial assessment visit</p>	G 236		3/18/14	

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G 236	<p>Continued From page 36</p> <p>-At regular intervals, as appropriate, while the patient is receiving care, treatment and/or services through Agency based upon the patient's clinical status."</p> <p>A "PT VISIT" note, dated 12/19/13, included documentation of 2 wounds: "Left lower leg has cozing sores on posterior lower calf. Wound size on back of calf is approximately 10 cm width, 4 cm height. Lateral wound is about 3 cm width and 8 cm height."</p> <p>Patient #2's record included a signed physician's order for SN visits for wound care dated 12/19/13.</p> <p>"SKILLED NURSE PROGRESS NOTES" included the following documentation of Patient #2's wounds:</p> <p>-12/20/13, "Patient has abrasion to left inner leg." The nurse documented she performed wound care. She did not include documentation of the second wound identified by the physical therapist on 12/19/13. The note included a section, titled "Wound 1," which further detailed information about the wound. Measurements were documented as 3 cm by 1 cm.</p> <p>-12/21/13, "Drainage from a large blister on medial side of left lower extremity was yellowish green as was the large blister on the lateral side of left lower extremity." The nurse documented wound care was performed, but did not indicate to which wound. The wound notes identified the wounds as "Wound 1," which further detailed information about the wound, and its measurements as 3 cm X 1 cm. However, it did not indicate which wound was being referenced.</p>	G 236			

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G 236	<p>Continued From page 37</p> <p>-12/23/13, "Patient has increased drainage, swelling and redness to the left lower leg." The nurse documented wound care was performed, but did not indicate whether it was performed on 1 or 2 wounds. The wound notes identified the wound as "Wound 1," on the left leg. Measurements were documented as 3 cm X 1 cm. There was no measurement of a second wound.</p> <p>-12/26/13, "Patient now has 3 areas of open skin on the left lower leg with drainage." Wound care was documented, however, the nursing note did not identify which wounds received the wound care. The wound notes identified the wound as "Wound 1," documented location as the left leg. No measurements were included.</p> <p>12/30/13, "Has decreased drainage today, but two small open areas that are new." Wound care was documented, however, the nursing note did not identify which wounds received the wound care. The wound notes identified the wounds as "Wound 1," (left leg outer) and "Wound 2," (left leg inner). No measurements of the wounds were noted.</p> <p>1/06/14, "Patient now has 3 areas of open skin on the left lower leg with drainage." Wound care was documented, however, the nursing note did not identify which wounds received the wound care. The wound notes identified the wounds as "Wound 1,"(left leg outer) and "Wound 2," (left leg inner). No measurements of the wounds were noted.</p> <p>1/10/14, "Leg swelling and drainage improving." The nurse documented she provided wound care, however, the nursing note did not identify which</p>	G 236			

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G 236	<p>Continued From page 38</p> <p>wounds received the wound care. The wound notes identified the wounds as "Wound 1," (left leg outer) and "Wound 2," (left leg inner). No measurements of the were noted.</p> <p>1/14/14 Narrative stated, "Leg swelling and drainage improving" Wound care was documented, however, the nursing note did not identify which wounds received the wound care. The wound notes identified the wounds as Wound 1(left leg outer) and Wound 2 (left leg inner.) No measurements of the wounds were noted.</p> <p>1/21/14, "One small 1 by 1 open area draining yellow liquid scant amount, prior open areas to inner leg are now healed." The nurse did not identify which wound remained open, and which wound was healed.</p> <p>1/28/14, "Wound right below knee was bleeding today." "Now has open areas on upper outside of leg from scratching leg." The nurse documented she provided wound care, however, the nursing note did not identify which wounds received the wound care. The wound notes identified the wounds as "Wound 1," (left leg outer) and "Wound 2," (left leg inner). Wound measurements were not documented.</p> <p>1/31/14, "Patient continues to have redness, swelling and draining wounds to left leg." The nurse documented she provided wound care, however, she did not identify which wounds received the wound care. The wound notes identified the wounds as "Wound 1," (left leg outer) and "Wound 2," (left leg inner.) No measurements were noted.</p>	G 236			

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G 236	<p>Continued From page 39</p> <p>In an interview on 2/07/14 at 4:00 PM, the DCS reviewed Patient #2's record and confirmed wound measurements were not completed on a regular basis and documentation was inconsistent. He stated he thought the agency practice was to document wound measurements once a week although it is not stated in the policy.</p> <p>Documentation, which included wound measurements, regarding Patient #2's leg wounds was inconsistent.</p> <p>2. Patient #4 was a 50 year old male referred by his physician on 1/16/14 (a Thursday), for physical therapy services related to backpain.</p> <p>Patient #4's "HOME HEALTH CERTIFICATION AND PLAN OF CARE," noted his Start of Care Date, as 1/18/14.</p> <p>Consent forms and other agency documents were signed by Patient #4 and dated 1/19/14.</p> <p>A physician order request dated 1/19/14, signed by an RN, noted "Patient was opened to home health services on 1/19/14. They are expecting a visit from PT on 1/20/14."</p> <p>In an interview on 2/07/14 at 1:15 PM the physical therapist who performed the initial assessment, stated an RN went out on Sunday, 1/19/14, to "Open" Patient #4 to home health. The therapist stated it was his understanding the SOC date was the date consents were signed.</p> <p>In an interview on 2/07/14 at 3:15 PM, the DCS confirmed the dates of the consents and SOC were inconsistant.</p>	G 236			

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G 236	<p>Continued From page 40</p> <p>Patient #4's medical record contained conflicting dates.</p> <p>3. Patient #6 was an 87 year old female, admitted to the agency on 7/20/13, for SN and PT services related to late effect cardiovascular disease, depressive disorder, spinal stenosis, colostomy and foley catheter care.</p> <p>Patient #6's POC for certification period 7/20/13 to 9/17/13, did not include orders for HHA visits. An order request to Patient #6's physician was dated 7/24/13. The order request did not include a physician signature. The record did not include documentation that a verbal order for HHA services had been obtained from the physician.</p> <p>The "HOME HEALTH AIDE CARE PLAN," was dated 7/24/13, and signed by the RN who completed Patient #6's initial assessment. However, the first HHA visit was documented as 7/23/13, indicating the aide provided services before the HHA POC was developed.</p> <p>During an interview on 2/10/14 at 3:00 PM the DCS reviewed Patient #6's record and confirmed the request to the physician for orders for HHA services was not signed. He stated upon performing a chart audit, the agency determined orders for the HHA services were not present in Patient #6's record. He stated he initiated the order request to the physician on 9/17/13. He confirmed the date of the request was back dated and not accurate.</p> <p>Patient #6's record included inaccurate and incomplete information.</p>	G 236			
G 332	484.55(a)(1) INITIAL ASSESSMENT VISIT	G 332		3/18/14	

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G 332	Continued From page 41 The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. This STANDARD is not met as evidenced by: Based on review of patient medical records, agency policies, and staff interviews, it was determined the agency failed to ensure the initial patient assessment was completed within 48 hours from physician referral for 3 of 8 patients (#4, #6, and #8) whose records were reviewed. This had the potential to result in a delay of treatment and unmet patient needs. Findings include: The CMS OASIS Item Guidance for M0030, includes: "A reimbursable service must be delivered to be considered the start of care." The agency's policy "PATIENT ASSESSMENT," undated, stated a comprehensive initial assessment of the patient was to be completed within 48 hours of referral to the agency. The policy was reviewed and approved by the agency's PAC in April 2013. Patients were admitted to the agency with a SOC date which was prior to the initial assessment and skilled visit. Examples as follows: 1. Patient #4 was a 50 year old male referred by his physician on 1/16/14 (a Thursday), for physical therapy services only. Consent forms and other agency documents were signed by Patient #4 and dated 1/19/14.	G 332			

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G 332	<p>Continued From page 42</p> <p>A physician order request dated 1/19/14, signed by an RN, noted "Patient was opened to home health services on 1/19/14. They are expecting a visit from PT on 1/20/14."</p> <p>The SOC was dated 1/18/14, however, the initial assessment and OASIS was performed by the therapist during his first visit on 1/20/14, (Monday), which was 4 days after the physician referral.</p> <p>In an interview on 2/07/14 at 1:15 PM, the physical therapist who performed the initial assessment, stated an RN went out on Sunday 1/19/14, to "Open" Patient #4 to home health. During that visit she was to check Patient #4's medication list and get any required documents and consents signed. He confirmed only PT had been ordered. The therapist stated it was his understanding the SOC date was the date consents were signed.</p> <p>In an interview on 2/07/14 at 3:15 PM, the DCS described what the term "The patient was opened," referred to. He stated when referrals are on Friday evenings or on the weekend, the RN covering the weekend shift would be sent out to have the consents signed and that would determine the SOC date. He stated the weekend nurse would go to "open" all patients, including those with therapy only orders. The DCS confirmed the SN visit was not ordered by the physician and stated it was a non-billable visit. The DCS was unable to determine why the SOC was dated 1/18/14, although Patient #4 had signed the consents dated 1/19/14.</p> <p>The agency did not ensure Patient #4's initial assessment was performed within 48 hours from</p>	G 332		
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G 332	<p>Continued From page 43 the time of referral.</p> <p>2. Patient #6 was an 87 year old female, referred by her physician on 7/18/13, (a Thursday), for SN and PT services related to late effect cardiovascular disease, depressive disorder, spinal stenosis, colostomy and foley catheter care.</p> <p>Consent forms and other agency documents were signed by Patient #6 and dated 7/20/13.</p> <p>The SOC was noted as 7/20/13, however, the initial assessment and OASIS was not performed until the nursing visit on 7/22/13, (a Monday), which was 4 days after the physician referral.</p> <p>A physician order request, by a different RN, dated 7/22/13, noted "Patient was opened to home health services on 7/20/13. They are expecting a visit from RN on 7/23/13."</p> <p>During an interview on 2/07/14 at 3:15 PM, the DCS defined the meaning of the statement "The patient was opened," that was documented frequently in the patients' records. He stated the agency did not routinely perform initial assessment and OASIS visits on the weekend. He stated the weekend nurse would see the patient and ensure the consents and required agency documents were signed. He stated the therapist or RN would be assigned on Monday and would perform the comprehensive assessment and SOC OASIS.</p> <p>The agency did not ensure Patient #6's initial comprehensive assessment was performed within 48 hours from the time of referral.</p>	G 332			

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G 332	Continued From page 44 3. Patient #8 was an 85 year old female referred by her physician on 4/12/13, (a Friday), for physical therapy services only. The SOC was noted as 4/15/13, however, the initial comprehensive assessment and OASIS was not performed until the first therapy visit on 4/15/13, (a Monday), which was 3 days after the physician referral. During an interview on 2/07/14 beginning at 1:40 PM, the Physical Therapist who had performed the initial assessment of Patient #8, reviewed her medical record and confirmed he had exceeded the 48 hours after physician referral. The therapist stated it was his understanding he would be able to wait when referrals were sent in on Fridays. The agency did not ensure Patient #8's initial assessment was performed within 48 hours from the time of referral. During an interview on 2/07/14 at 3:15 PM, the DCS stated the SOC was the date the patient signs the consent authorizing permission for home health services. After review of the agency policy which was reviewed and approved by the PAC in April 2013, he confirmed their policy correctly reflects the CMS requirement that admission assessments be performed within 48 hours of the time of referral or on the physician ordered SOC date. The agency did not perform initial assessments within 48 hours of referral.	G 332		
G 337	484.55(c) DRUG REGIMEN REVIEW	G 337		2/18/14

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G 337	<p>Continued From page 45</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review, policy review, medication review completed during home visits, and staff interviews, it was determined the agency failed to ensure the drug review was comprehensive for 4 of 8 patients (#2, #4, #6, and #7) whose records were reviewed. This had the potential to place patients at risk for adverse events or negative drug interactions. Findings include:</p> <p>1. Patient #2 was a 62 year old male admitted on 12/12/13, for physical therapy services related to late effect hemiplegia, muscle weakness and depressive disorder.</p> <p>The SOC OASIS, dated 12/12/13, section M2000 was answered "No," indicating no problems were identified during the medication review.</p> <p>During an interview on 2/07/14 at 2:30 PM, the physical therapist for Patient #2 stated he did not know how to check for medication interactions and stated he thought the nurse in the office who reviewed the POC did that. He stated he was unsure how he would be informed if an interaction was identified.</p> <p>The agency failed to ensure Patient #2's comprehensive assessment included identification of significant drug interactions with</p>	G 337			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 337	<p>Continued From page 46 his medications.</p> <p>2. Patient #4 was a 50 year old male, admitted on 1/18/14, for physical therapy related to backache. Additional diagnoses include hypothyroidism, esophageal reflux, paranoid schizophrenia and obsessive compulsive disorder.</p> <p>A visit was conducted on 2/06/14 at 10:00 AM, to observe PT services at the ALF where Patient #4 resided. Patient #4's medications were reviewed with the staff and compared to the medications listed on his POC. Discrepancies were noted as follows:</p> <p>The POC noted Diazepam 5 mg twice a day prn. The ALF medication record noted Diazepam 5 mg, 1 tablet every 8 hours.</p> <p>The POC noted Tylenol 650 mg ER tab every 8 hours prn. The ALF medication record noted Acetaminophen (generic Tylenol) 650 mg 1 tab every 6 hours prn.</p> <p>The following meds were noted on the ALF medication record and were not included on Patient #4's POC:</p> <p>Oxycodone 5/325 mg 1 tablet every 4-6 hours pm Ketorolac 10 mg, 1 tablet 4 times a day Pseudoephedrine HCL 1-2 tabs every 6-12 hours prn Artificial tears, 1 drop to eyes pm</p> <p>In an interview on 02/07/14 at 1:15 PM, the physical therapist for Patient #4 stated he did not know how to check for medication interactions and he did not know if that was done by a nurse in the office. He stated he had not been given</p>	G 337			

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

PRINTED: 04/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137079	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/10/2014
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G 337	<p>Continued From page 47</p> <p>direction from the agency to determine how to accurately answer the medication review questions M2000 and M2002 when he completed an OASIS assessment.</p> <p>The agency failed to ensure Patient #4's comprehensive assessment included a review of all medications the patient was taking, including identification of significant drug interactions.</p> <p>3. Patient #6 was an 87 year old female, admitted to the agency on 7/20/13, for SN and PT services related to late effect cardiovascular disease, depressive disorder, and spinal stenosis.</p> <p>Patient #6's record documented she was hospitalized on 8/06/13, and the agency resumed care on 8/23/13.</p> <p>The POC for the certification period 07/20/13 to 09/17/13, was signed by Patient #6's physician on 7/22/13.</p> <p>Patient #6's record included a "MEDICATION PROFILE," dated 8/26/13. The medications on her POC differed from the profile which was completed after she resumed home health services. There was no indication Patient #6's medications were reviewed and updated after her resumption of care. The profile dated 8/26/13, was not signed by her physician.</p> <p>The profile included the following additions that were not on Patient #6's POC for the certification period 07/20/13 to 09/17/13:</p> <p>Prilosec 20 my daily Lasix 20 mg daily Potassium Chloride 20 meq daily</p>	G 337		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

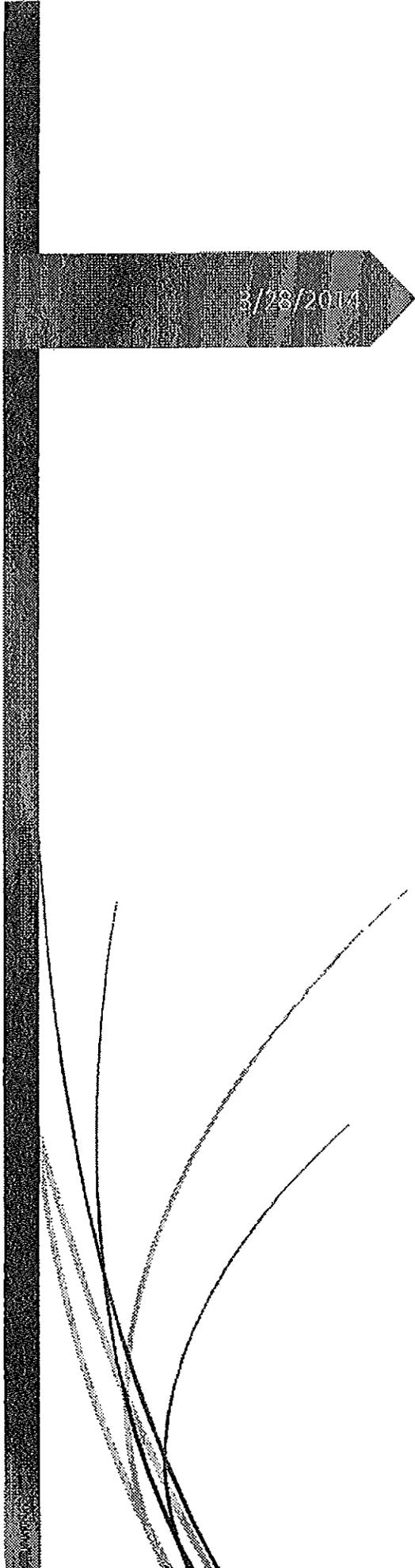
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G 337	<p>Continued From page 48</p> <p>Digoxin 125 mcg daily Avapro 300 mg daily Amlodipine 5 mg daily Vitamin B12 IM monthly</p> <p>Patient #6's profile did not include the following medications listed on her POC for the certification period 07/20/13 to 09/17/13, so it was unclear if they were meant to be discontinued:</p> <p>Norco 7.5 mg-325 mg 1/2 tablet at bedtime Metoprolol 100 mg twice daily Nexium 20 mg PRN</p> <p>During an interview on 2/07/14 at 3:15 PM, the DCS reviewed the record and confirmed a review of Patient #6's new or changed medications was not performed. The DCS confirmed Patient #6's physician had not been contacted accurately verify her medications after her hospitalization.</p> <p>The agency failed to ensure Patient #6's medications were reviewed at the resumption of care.</p> <p>4. Patient #7 was a 70 year old female admitted to the agency on 6/15/13, for PT services related to backache. Additional diagnoses include hypertension and hypothyroidism.</p> <p>The SOC 6/15/13, was completed by the physical therapist. On the OASIS, in section M2000, he answered "No" indicating no problems were identified during medication review.</p> <p>During an interview on 02/07/14 at 3:15 PM, the DCS reviewed Patient #7's record and confirmed a medication review for interactions had not been completed. He stated the physical therapists</p>	G 337			

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

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G 337	Continued From page 49 have not been taught how to check for medication interactions. The agency failed to ensure a thorough review of Patient #7's medications during the comprehensive assessment.	G 337			



3/28/2014

Family Home Health

Plan of correction survey results 2014

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ACKNOWLEDGMENTS

As Administrator of Family Home Health I Julie Hendren acknowledge these changes as identified by the plan of correction document. I further will do all within my capacity to ensure that the following changes are implemented and followed as identified. I understand deviations from the conditions of participation as outlined by State and Federal regulations must be corrected timely.

Julie Hendren, Administrator

Date

G 101: 484.10 PATIENT RIGHTS

Patients receiving care from Family Home Health with Medicare and Medicare HMO's being identified as the primary responsible payor will be notified of a discontinuation of home health services in written form at least 48 hours prior to the discharge date. This form identified for this notification is CMS 10123-NOMNC. If a patient or responsible party refuses, denies, or wishes to discontinue home health services then their right of receiving written notification of discharge 48 hours prior is waived. Tracking will be managed by Intake Coordinator. No patient will be discharged prior to being case conferenced, unless patient / responsible party requests immediate discharge, upon plan for discharge the intake coordinator will disperse the NOMNC for completion at the next clinical visit. The form will be returned to the office and uploaded to the patients chart.

Implementation Process

The NOMNC Form where previously was generated and signed by the patient at the initial visit will now not be generated until the patient is case conferenced for a discharge. Upon Case Conference when discharge planning has been put into place and the care team agrees that the patient will be ready for discharge the NOMNC form will be generated and explained to the patient. This will be done minimum 48 hours prior to the planed discharge date. The patient will be provided an additional copy for their records.

Compliance Validation: Intake Coordinator

Tracking of the NOMNC form will be monitored by the intake coordinator. All patients with Medicare and Managed Medicare will be tracked for the following: Date Issued, Clinician responsible for signature, Date returned, Date Signed by the Patient. The form will be uploaded into the patients chart once it is returned by the clinician. Furthermore the NOMNC will be checked in the QA process during the final chart review.

Implementation Date: 04/01/14

G 104: 484.10(b)(1)&(2) EXERCISE OF RIGHTS AND RESPECT FOR PROP

Patients will receive care from Family Home Health in accordance to their rights and responsibilities.

Furthermore a patient will be provided a copy of their rights and responsibilities prior to admission to home health services. If a patient has been legally identified as incompetent for health care decisions then all consents will be signed by their responsible party. No care will be rendered to a patient prior to signed consent for admission and understanding of patient rights and responsibilities.

Patients that have been identified as legally incompetent for healthcare decisions must have either an appointed guardian or a power of attorney appointed as their responsible party. All decisions about home health services and consent for treatment will be approved by the responsible party.

Implementation Process

All patient are presumed to have decision-making capacity unless a determination to the contrary has been made by legal authority. Upon receiving a referral the intake coordinator will call the patient / responsible party to setup an appointment. The Intake coordinator will ask at that time if the patient has legal capacity to sign for themselves, if it is identified that the patient does not have this capacity the responsible party will be requested to be present for the initial visit and to sign consents.

The Intake Coordinator will notify the Director of Clinical Services.

Compliance Validation: Direction of Clinical Services

The Director of Clinical services will monitor closely the chart of any patient who has been identified as legally incompetent. Monitoring will include tracking to ensure a copy of the legal documentation validating the patient has been deemed legally incompetent is kept in the patient's medical record. If at any point throughout the patients time on services that they become legally incompetent the legal forms will be requested and put into the patient chart. Once the documentation is confirmed all team

members will be notified via communication note that the patient has been legally identified as incompetent and does not have the capacity for decision making. All consents for treatment or ending services must be signed by the appointed responsible party.

Implementation Date: 04/01/14

G 143: 484.14(g) COORDINATION OF PATIENT SERVICES

All disciplines involved in patient care will coordinate their care with the multidisciplinary team. All members of the team must be notified prior to a discontinuation of service from any discipline. All team members will coordinate their care with other team members periodically throughout the duration of home health services, and with any changes in the patient's plan of care. If a visit or discipline is declined by the patient that information will be provided to all pertinent team members. Coordination of care also includes the physician via physician order forms.

Furthermore, a weekly communication status update will be completed by the case manager and sent via communication notes to all team members involved in the patient's plan of care. Patient care manager will ensure that communication notes are completed at least weekly.

Implementation Process

Weekly updates are to be completed by disciplines involved in the patient's care and sent to the other team members involved in the patient's care as well as to the director of clinical services. If a discipline is planning to discontinue their services the entire team will be notified in the weekly update no later than the previous week prior to discharge. Communication notes are sent to physicians as FYI's only and do not require a physician response, however if signed and returned by the physician the communication note may be referred to as physician orders.

Compliance Validation: Patient Care Manager

The Patient care manager will keep a list of all currently active patients and which disciplines are involved with the patient. Each week the Patient care manager will track to ensure the patients each have a weekly update communication note from at least one discipline involved in the patient's care.

Implementation Date: 04/01/14

G 145: 484.14(g) COORDINATION OF PATIENT SERVICES

A written summary report for each patient will be available and sent to the physician least every 60 days. All 60 day summaries will be marked as orders to be sent to the physician. Quality Assurance will monitor summaries daily and ensure that "Send as an Order" button is selected. Upon chart review Quality Assurance Team will double check that a 60 day summary was sent to the physician for each certification episode.

Implementation Process

Upon admission to home health the Intake Coordinator will scheduled in the patients chart a 60 day summary for each ordered discipline. Any time a discipline is added to a patient after the initial start of care the Intake Coordinator will be notified by the clinician. The Intake Coordinator will then schedule for the newly added discipline a 60 day summary. The Intake Coordinator will track all patients and will ensure that the 60 day summary is completed by each discipline within the last two weeks of the patient's certification period. If the patient is recertified the Intake Coordinator will again schedule for any remaining disciplines a 60 day summary.

Compliance Validation: Quality Assurance Team

The Intake coordinator will notify the Director of Clinical Services of any clinician that does not complete their required 60 day summary on time. The Director of Clinical Services will proceed with disciplinary or corrective action.

Implementation Date: 04/01/14

G 158; 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER

Each patient will have a plan of care approved by a licensed physician for each certification that they are on home health services. All care provided will be rendered in accordance to the plan of care. Any changes in care, treatments, or patient condition will be clarified with the physician prior to administration of such.

No care will be provided to any patient without specified written and / or verbal authorization from a physician. Furthermore all verbal orders will contain the name and title of the person giving the verbal order.

All visit frequencies will be projected at the start of services and any deviation from the frequency will be updated with physician approval. Patient will not receive visits from any discipline that has not been ordered either verbally or written from a licensed physician.

Implementation Process

Previously our process for receiving patient referrals and initiating their start of care was out of compliance as we were occasionally completing a consents visit as our initial visit. We have removed the consents visit and will no longer allow an initial visit to be done by a non-ordered discipline.

All initial visits will include the completion of the OASIS-C Start of care by the ordered discipline case manager. Upon completion of the OASIS-C a 485 plan of care will be generated. The proposed plan of care will be called to the physician for verbal orders the day of the initial visit. If verbal orders are unable to obtain the clinician will notify the Director of Clinical Services. The Director of Clinical Services will track the proposed plan of care to ensure that it is faxed and received with physician signature. No further visit beyond the initial evaluations for each discipline will be scheduled without either verbal or written orders for continued care.

Compliance Validation: Director of Clinical Services

Any deviation from the above specified instructions will be reported by the Compliance Validation Team to the Director of Clinical Service and Administrator. Identified deviations will be resolved and corrective action will be taken to ensure future compliance with regulations.

Implementation Date: 04/01/14

G 159: 484.18(a) PLAN OF CARE

The patient's plan of care will contain detailed pertinent health history, goals for home health, projected interventions, and treatments, current medications, and all durable medical equipment. The plan of care will be periodically updated with physician approval. All therapies will have their evaluations each certification sent and signed by the physician for detailed approval of therapy treatments. Quality Assurance will monitor each day all evaluations submitted to ensure "Send as Order" button is selected. All goals, interventions, and therapies will be set within realistic expectations of patient's regaining / maintaining health status. No changes will be made to the plan of care without written physician orders.

Implementation Process

After the initial plan of care is generated the Director of Quality Assurance will review the plan of care for accuracy. Once approved by the Director of Quality Assurance the plan of care will not be changed without orders. All orders sent and received will be approved and returned through QA. If an order updates the plan of care the Director of Quality Assurance will send a communication note to the care team indicating that the order has been received and the plan of care has been updated. All Evaluations from each discipline will be sent to the physician for approval of treatments. The Director of Quality Assurance will review evaluations daily as they are completed.

Compliance Validation: Director of Quality Assurance

The Director of Quality Assurance will review daily visit notes as they are turned in. If any deviation from the plan of care is identified the Director of QA will notify the Clinician and ask for clarification orders to be written. QA will also notify the Director of Clinical Services for review of further corrective or disciplinary action.

Implementation Date: 04/01/14

G 164: 484.18(b) PERIODIC REVIEW OF PLAN OF CARE

Communication to the physician will be documented on physician orders. Orders will be sent to update the plan of care periodically at least every 60 days or with any changes in care, treatments, or patient condition. The plan of care will not be changed without physician orders. Any changes made to the plan of care will be communicated with the care team. The plan of care will be reviewed regularly by team members to ensure that care is being rendered in accordance to the plan of care and that goals and interventions are being assessed for effectiveness. Visits from each discipline involved in patients care will be rendered as projected in the plan of care. Any deviations in visits must be approved by a physician. All visits will constitute a skilled service. If no skilled services can be identified for a discipline then that discipline with notification to the physician and patient will discontinue their visits. All discharges will be planned and approved by the physician prior to discharge, unless the patient / responsible party exercises their right to discontinue services early. The physician will be notified of all home health discharges, Patient's discharge status and reason for discharge.

Implementation Process

All care that affects or changes the plan of care will be written as physician orders and will not be implemented until verbal or written approval is received. Whenever an order is written and received back with the physician signature the Director of Quality Assurance will send out a communication note to all members in the care team indicating that an order has been received that updates the plan of care. The specific order will be identified in the communication note for the care teams' review. Part of the weekly update communication note will include if any discipline is planning for discharge.

Compliance Validation: Director of Clinical Services

The Director of Clinical Services will review updates for indications of appropriate care, goals, and discharge planning. The Director of Clinical Services will ensure that care, goals and discharge planning

follow the plan of care and justify skilled services. If skilled need is questioned the Director will ask the clinician for more information. If it is determined there is no longer a skilled need the patient and physician will be notified discharge planning will finalize ending patient's home health service.

Implementation Date: 04/01/14

G 236: 484.48 CLINICAL RECORDS

All clinical records will contain pertinent and accurate health care information. Clinical records contain patient demographics, following physicians, current medication profile, diet, treatments, list of durable medical equipment, permitted activity, signed orders, signed progress notes, summaries of care, discharge summary.

Updates in any category will be communicated with the primary physician and will be stored in the clinical record. Charts will be assessed by Quality Assurance Team for completeness any discrepancies will be clarified with the physician upon chart review.

Implementation Process

Periodic chart reviews will be completed to assess for accuracy and completeness. The Director of Clinical services will randomize active patients that are within the last 3-4 weeks of a certification period. A minimum of four patient charts will be reviewed each month. A record of which charts are audited will be kept detailing the findings of each chart review.

Compliance Validation: Director of Clinical Services

The Director of Clinical Services will review findings of periodic chart audits and will address any corrective or disciplinary actions.

Implementation Date: 04/01/14

G 332: 484.55(a)(1) INITIAL ASSESSMENT VISIT

All patients will be opened to services within 48 hours of referral date unless otherwise specified by physician or patient request. Any delay in initialization of services past 48 hours from the date of referral will be document and communicated to the physician. Initial assessment visit will include completion of CMS Form OASIS-C Start of Care, signed consent, and medication profile review. Initial assessment visit will be completed by one of the following physician ordered Registered Nurse, Physical Therapist, or Speech Therapist.

Upon admission the RN, PT, or ST will:

- Review patient demographics for accuracy
- Explain Patient Consent Forms
- Verify understanding and signature of consents prior to care
- List all following Physicians
- Record and clarify Health Information:
 - Medication Profile
 - High Risk Drug Review
 - Diet
 - DME
 - Permitted Activity Level
 - Pertinent Diagnosis
 - Allergies
 - Homebound Status
 - Systems review

If patient has wounds the RN, or PT will identify: (ST – Will get physician orders for SN or PT)

- Wounds upon admission
 - Initial Measurements Including
 - Odor
 - Drainage type, amount
 - Tunneling
 - Undermining
 - Stage (if pressure ulcer)
 - Interventions and Treatments
 - Goals
- Wound Updates
 - Weekly Measurements
 - Physician orders for treatment changes
 - Progress towards goals

Implementation Process

A record of referrals will be kept indicating the referral and start of care dates, and the ordered disciplines. Upon completion of each of the ordered disciplines initial visits the Intake Coordinator will be notified to update the clinical record. If initial visits are not completed within 48 hours of the referral date an order detailing why will be scheduled by the intake coordinator for each necessary discipline. The physician will be notified of the reason for the delay in service.

Upon completion of the initial visit the clinician will notify the Intake coordinator. The clinician completing the initial visit will turn in all associated forms to the Intake Coordinator, including The Oasis-C Start of Care which will be completed within 48 hours of the initial visit. The intake coordinator will

track the referral date for compliance, verify signed consents and will reassign the clinical documentation to QA for review of clinical content.

Compliance Validation: Director of Clinical Services & Director of Quality Assurance
Deviations from the required 48 hour referral time will be reported by the Intake Coordinator to the Director of Clinical Services for review and corrective or disciplinary action.

The Director of Quality Assurance will clarify with the clinician any discrepancies found in the initial assessment for review and correction.

Implementation Date: 04/01/14

G 337: 484.55(c) DRUG REGIMEN REVIEW

Upon admission RN, PT, or ST will perform a comprehensive medication profile assessment. Assessment will include a complete medication profile review, drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance:

All medications will include

- Name
- Dose
- Strength
- Route
- Frequency
- Reason for Use

Patient will be assessed for understanding and correct use of medication as ordered by their physicians.

Any discrepancies identified will be clarified with the physician via recently updated Medication

Clarification Form. Medication profile will be assessed for drug to drug interactions using LexiComp Drug

Assessment Tool any identified interactions will be clarified within one calendar day by the physician.

Any patient identified as taking a "High Risk" will receive instruction on how and when to report problems that may occur.

No changes will be made to the medication profile without physician orders. Quality Assurance Team

will ensure all medications are correct on the medication profile as ordered by the physician.

High Risk Medications:

- Anticoagulants
- Hypoglycemics

- Insulin
- Narcotics / Opioids
- Antiarrhythmics
- IV Medication / Parenteral Nutrition
- Injectable Medication
- Family Home Health Staff educated on High Risk Medications resource tool:
<http://www.ismp.org/tools/highalertmedications.pdf>

Implementation Process

Upon admission and with any changes to the patient's medication profile, the clinician will identify and provide education to the patient / responsible party of all their High Risk Medications. Major Drug Interactions will be reported to the physician via Medication Clarification order. The medication clarification order will be generated for each episode by the intake coordinator and assigned to the case manager.

Compliance Validation: Director of Quality Assurance

The Director of QA will review the medication profile upon the start of care, recertification, and resumption, also when medication orders are received. The identified high risk medications will be listed on the Oasis along with the provided education for those identified medications. The Director of Quality Assurance will review this section of the Oasis for accuracy and completeness. If any additional medications are identified the Director of QA will notify the clinician via communication note to provide the additional education of high risk drugs at their next visit.

Implementation Date: 04/01/14

Addendums



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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April 4, 2014

Julie Hendren, Administrator
Family Home Health
1020 North Hickory Avenue, Suite 100
Meridian, ID 83642-8006

RE: Family Home Health, Provider #137079

Dear Ms. Hendren:

On **February 10, 2014**, a complaint survey was conducted at Family Home Health. The complaint allegation, finding, and conclusion are as follows:

Complaint #ID00006083

Allegation: The agency initiated services to a patient in an ALF without informing the ALF. The agency did not have an agreement with the ALF and did not coordinate the patient's care with the facility.

Finding: An unannounced visit was made to the home health agency 2/05/14 to 2/10/14 to investigate the complaint. During the investigation, surveyors reviewed 8 medical records of patients who resided in Assisted Living Facilities (ALF). The surveyors completed 2 home visits, interviewed patients, ALF and agency staff, and reviewed policies and procedures.

During an interview on 2/07/14 beginning at 1:05 PM, the Director of Clinical Services explained the agency's process related to services provided to patients residing in ALF's. Upon receiving a referral and physician's order, an agency representative called the ALF to inform them of the start of care date. He further stated the home health clinicians signed in at the ALF. After each visit the agency faxed a copy of the clinician's visit note to the ALF.

A document called "HOME HEALTH AGREEMENT" was reviewed. The Director of Clinical Services stated this agreement was signed by the home health agency and a representative of the

Julie Hendren, Administrator
April 4, 2014
Page 2 of 2

ALF before home health services were provided to ALF residents. The agreement includes the following statements: "Family Home Health will coordinate services with the Community's appropriate designated staff," "Family Home Health staff will provide a copy of the documentation that Family Home Health retains in it's records," and "Family Home Health will provide a copy of physicians' orders regarding the residents of the community."

Interviews were completed with the Administrators of 2 ALF's following home visits. Both Administrators stated they were satisfied with the communication they received from Family Home Health when services were provided to their residents.

There was lack of sufficient evidence to determine the agency failed to coordinate care with ALF staff when home health services were provided in the ALF.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pmt