



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
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**CERTIFIED MAIL: 7007 3020 0001 4038 9871**

March 12, 2014

Jana Stowell, Administrator  
St Alphonsus HHA & Hospice, An Amedisys Partner  
9199 West Black Eagle Drive  
Boise, ID 83709-1572

RE: St Alphonsus HHA & Hospice, An Amedisys Partner, Provider #137006

Dear Ms. Stowell:

Based on the survey completed at St Alphonsus HHA & Hospice, An Amedisys Partner, on February 24, 2014, by our staff, we have determined St Alphonsus HHA & Hospice, An Amedisys Partner is out of compliance with the Medicare Home Health Agency (HHA) **Conditions of Participation of Organization, Services & Administration (42 CFR 484.14) and Acceptance of Patients, POC, Med Super (42 CFR 484.18)**. To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused these conditions to be unmet, substantially limit the capacity of St Alphonsus HHA & Hospice, An Amedisys Partner, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

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

An acceptable Plan of Correction contains the following elements:

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

Jana Stowell, Administrator  
March 12, 2014  
Page 2 of 2

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

**Such corrections must be achieved and compliance verified by this office, before April 10, 2014. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than April 1, 2014.**

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **March 25, 2014.**

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

We urge you to begin correction immediately.

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

Sincerely,



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

SC/pmt

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

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

PRINTED: 03/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/24/2014
NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER			STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709	
(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)	(X6) COMPLETION DATE
G 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the Medicare recertification survey of your home health agency from 2/18/14 through 2/24/14.</p> <p>The surveyors conducting the recertification were:</p> <p>Gary Guiles, RN, HFS, Team Leader Susan Costa, RN, HFS Nancy Bax, RN, HFS Don Sylvester, BSN, RN, HFS</p> <p>Acronyms include:</p> <p>cg - care giver CKD - Chronic Kidney Disease CM - Clinical Manager CP - care plan DME - Durable Medical Equipment ER - Emergency Room ESRD - End Stage Renal Disease eval - evaluation HHA - Home Health Aide HTN - hypertension INR - International Normalized Ratio, a laboratory test for clotting time JP Drain - Jackson Pratt drain, a portable wound suction device LPN - License Practical Nurse MSW - Medical Social Worker NKA - No Known Allergies OT - Occupational Therapy POC - Plan of Care Pt - patient PT - Physical Therapy SN - Skilled Nurse SNF - Skilled Nursing Facility SW - Social Work</p>	G 000	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;">MAR 25 2014</p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p>	

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

TITLE

(X6) DATE

*Sara Small RN, D.O.O.* 3/24/14

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

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G 000	Continued From page 1	G 000			
G 122	TIA - Transient Ischemia Attack Type II DM - Type 2 diabetes 484.14 ORGANIZATION, SERVICES & ADMINISTRATION	G 122			
	This CONDITION is not met as evidenced by: Based on staff interview and review of clinical records and agency policies, it was determined the agency failed to ensure administrative systems were developed and maintained. This resulted in a lack of support and guidance to agency personnel. Findings include:  1. Refer to G132 as it relates to the governing body's failure to oversee the management of the agency.  2. Refer to G143 as it relates to the governing body's failure to ensure agency personnel coordinated services.  3. Refer to G144 as it relates to the governing body's failure to ensure coordination of care efforts by agency personnel were documented.  The cumulative effect of these systemic failures seriously impeded the ability of the agency to provide services of sufficient scope and quality.		G 122 This Condition will be met by agency to ensure the governing body provides direction and oversight to the agency. The corrective action plan will be outlined in each specific tag area G 132, G 143 and G 144.		
G 132	484.14(b) GOVERNING BODY  The governing body oversees the management and fiscal affairs of the agency.	G 132	G 132 The governing body will oversee the management and the fiscal affairs of the agency. The DOO, AVP, VP and governing body are responsible to ensure this standard is met.		

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G 132	<p>Continued From page 2</p> <p>This STANDARD Is not met as evidenced by: Based on staff interview and review of medical records and agency policies, it was determined the agency's governing body failed to oversee the management of the agency. This directly affected 2 of 16 patients (#2 and #16) whose records were reviewed and had the potential to affect all patients served by the agency. The lack of management resulted in a lack of direction and assistance to agency personnel. Findings include:</p> <p>1. The governing body did not have a defined system to oversee the management of the agency. The Area Vice-President was interviewed on 2/24/14 beginning at 10:00 AM. When asked about a policy that defined how the governing body maintained oversight of the management of the agency, she stated there was no such policy. When asked for documentation of oversight of the management of the agency, she stated there were no minutes or other documents to show the governing body was involved in oversight. She stated the only document she knew of was called a "Facility Report," and she stated she did not think it was available and thought it may be limited to access only within the company.</p> <p>In the same interview, the Area Vice-President was asked what the biggest problems facing the agency were. She stated the biggest problems were the day to day flow of information from field staff to office personnel and the timely entry of physician orders and the development of the POC. She also stated the entire nursing staff for the agency had turned over in the past 6 months. She stated there was no documentation she could provide to demonstrate how the governing</p>	G 132	<p>As outlined in Policy LD-001 Governing Body and LD-008 Policy and Procedure Formation (appendix A), the governing body has a defined system to oversee the management of the agency. The process is outlined in the policy. The DOO (director of operations) will meet weekly with the AVP (area vice president) either on site or via telephone effective the week of March 10th. Minutes will be maintained by the DOO in a binder maintained in the DOO office. The AVP then meets with her supervisor, the vice president every other week to discuss any issues that may have arisen in the past 2 weeks. This is a routine scheduled call. Additionally, the AVPs submit information to the VP and that information is posted to the Amedisys website accessible to the VP and governing body. Information included in this discussion is regarding timely starts of care, timely transmissions, acute care hospitalization rates, satisfaction scores and more. The AVPs also submit reports to the VP for all scores that do not meet expectations with the rationale and plans. Additionally, the AVPs send weekly commitments to the VP for any outstanding issues to include their</p>		

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G 132	<p>Continued From page 3</p> <p>body provided oversight to the agency in addressing these problems.</p> <p>The governing body had no formal means to ensure oversight of the agency occurred.</p> <p>2. The agency's medical records consisted of a hybrid paper and electronic medical record. During the survey, the Administrator and the Clinical Manager worked to obtain medical records for surveyors.</p> <p>On 2/20/14 at 9:20 AM, the Administrator stated she had not been trained to reproduce complete medical records for surveyors to review. She stated requests were sent to the corporate office to reproduce complete records.</p> <p>On 2/20/14 at 1:45 PM, the Clinical Manager stated she had not been trained to produce complete medical records. She stated records that were provided to surveyors were not complete. For example, she stated signed copies of POCs and supplemental orders were not provided with the medical records. She was asked who was in charge of medical records at the agency. She stated the Business Office Manager was in charge.</p> <p>The Business Office Manager was interviewed on 2/20/14 beginning at 1:50 PM. She stated she was responsible to ensure paper documents were filed in the correct sections in the paper medical record. However, she stated no person at the agency was designated responsible to ensure entire medical records were complete, accurate, and could be reproduced when needed.</p> <p>The Area Vice-President was interviewed on</p>	G 132	<p>plans and their efforts regarding these issues. The VP meets weekly with the Executive Vice President of Operations who is responsible for home health operations and oversight of information and technology for the company. The agenda for this meeting is determined by the weekly needs or issues of the agencies or company.</p> <p>Appendix B Organizational chart</p> <p>Appendix C Template for AVP/DOO weekly meeting</p> <p>Appendix D Governing body meeting minutes and approvals for manuals</p> <p>Monitoring Process: Each week the DOO and AVP will review these cited areas. The AVP will report to the VP weekly if areas are identified that the agency is not meeting the standard. The minutes of the meetings will be maintained in a binder in the DOO's office.</p>	

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G 132	<p>Continued From page 4</p> <p>2/24/14 beginning at 10:00 AM. She stated no staff at the agency had been trained to reproduce a complete medical record.</p> <p>The governing body failed to assign responsibility for oversight of medical records.</p> <p>3. The policy "Services Provided/Supervision of Disciplines-MSW and Dietician," revised 11/12, stated word for word the regulatory language at 42 CFR 484.34 Condition of Participation: Medical Social Services. Under the heading "PROCEDURE," the policy stated Medical Social Services "...may include...performing an initial medical social assessment." The policy did not define a psychosocial assessment nor did it state what such an assessment should contain.</p> <p>Two medical records documented psychosocial assessments. These Included:</p> <p>a. Patient #16's medical record documented a 94 year old female who was admitted for home health services on 11/23/13. She was currently a patient as of 2/21/14. Her diagnoses included muscle weakness and difficulty walking.</p> <p>Patient #16's medical record included a form titled "MSW EVAL/CP," dated 1/31/14 at 10:45 AM. The form included the following items:</p> <p>i. MSW CARE PLAN frequency and duration. ii. MEDICAL SOCIAL PLAN/INTERVENTIONS. Boxes checked under this heading were "MSW to evaluate financial/emotional issues that interfere with patient's recovery...Assessment of social and emotional factors...emotional support." iii. HOMEBOUND REASON iv. COORDINATION OF CARE</p>	G 132	<p>The DOO, Clinical manager and the AVP will be educated regarding the process of how to print out a chart as identified in Section 10 in the office operation manual and IM-008 Clinical Records. (Appendix E)</p> <p>The corporate MSW educator teaches a class weekly for new MSWs. The MSW will attend that class. Additionally, the MSW educator will meet via phone with the DOO, MSW and CM regarding how to complete a psychosocial assessment and appropriate documentation of findings.</p> <p>Policy AA-007d Services Provided MSW will also be reviewed with the DOO, CM and MSW to outline the services that should be provided by the MSW. (Appendix G)</p>		

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G 132	<p>Continued From page 5</p> <p>v. MEDICAL SOCIAL SERVICES TREATMENT PLAN. Under this item the social worker documented "Wants others to take full care of her...[Patient] will ignore, yell, refuse cares when upset at staff, family, her doc, etc. Will follow for possible emotional distress or mental health concerns. Spoke with [daughter's name]-very thankful for SW involvement." A psychosocial assessment for Patient #16 was not documented.</p> <p>A "CLINICAL NOTE ADDENDUM" by the Social Worker, dated 1/31/14 but not timed, stated she met with Patient #16's daughter and spoke with her at length. The addendum stated Patient #16's behavior caused her daughter stress and physical problems. A psychosocial assessment was not documented.</p> <p>Neither the evaluation nor the addendum included a psychosocial assessment for Patient #16.</p> <p>No other evaluation of Patient #16's social history or needs was documented in the medical record.</p> <p>The MSW was interviewed on 2/21/14 beginning at 2:25 PM. She confirmed the order for an evaluation of Patient #16 the week of 1/20/14. She stated no other assessment of Patient #16 was documented.</p> <p>b. Patient #2's medical record documented a 56 year old female who was admitted for home health services on 2/15/14. She was currently a patient as of 2/24/14. Her diagnoses included recent surgery for a fractured hip.</p> <p>An "MSW EVAL/CP," was dated 2/19/14 at 1:45 PM. It contained the same items as noted above</p>	G 132	<p>Monitoring process: 100% of all MSW evaluations will be added to the PI for audit in March and April to ensure the documentation demonstrates a psychosocial assessment was performed. If the documentation meets standards, the percentage will be decreased to 20% for audit ongoing as part of the quarterly PI. Once significant compliance is demonstrated, the DOO or designee will continue the audit of 10% of patient records. The results of these audits will be reported to the PI committee and any problems identified will be addressed at the Quarterly PI meetings held quarterly. The findings will also be discussed on the weekly AVP call as indicated.</p> <p>Completion date April 1, 2014</p>		

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G 132	Continued From page 6 for Patient #16. Under the heading "MEDICAL SOCIAL SERVICES TREATMENT PLAN," the evaluation stated "Feels safe at home, has cell phone with her at all times, declined cg agency list. Needs transportation resources-Self Rescue Manual provided with multiple transportation options. Pt optimistic." The evaluation did not document a psychosocial assessment.  The MSW was interviewed on 2/21/14 beginning at 2:25 PM. She stated there was no policy which defined the contents of a psychosocial assessment and no template which included items for a psychosocial assessment.  The governing body failed to define the minimum requirements for a psychosocial assessment.  4. The governing body failed to ensure systems to plan for care and supervise patients' medical care of were implemented. Refer to G 156, Condition of Participation 484.18, "ACCEPTANCE OF PATIENTS, POC, MEDICAL SUPERVISION".	G 132			
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 record review and staff interview, it was determined the agency failed to ensure staff maintained liaison to effectively coordinate efforts for 3 of 16 patients (#9, #10, and #14) whose	G 143	G 143 All personnel furnishing services maintain liaison to ensure their efforts are coordinated and the physician is informed of changes in the patient condition.  The DOO or designee will be responsible for correcting this deficiency and ensuring ongoing compliance.		

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G 143	<p>Continued From page 7</p> <p>records were reviewed. This had the potential to negatively impact quality and continuity of patient care. Findings include:</p> <p>The agency did not ensure communication and coordination of patient care as follows:</p> <p>1. Patient #10 was a 67 year old male admitted on 1/20/14 for SN, PT, OT, and MSW services after a fall which resulted in fractures of his lumbar vertebrae. Additional diagnoses included muscle weakness, abnormality of gait, arthritis, and alcohol abuse.</p> <p>a. The comprehensive assessment dated 1/20/14, described Patient #10 as a widower, and lived alone. The nurse who performed the assessment documented he described his pain at a 7/10 level, he was unable to move out of his recliner, and urinated into a pitcher on the table. Additionally, the assessment included Patient #10 was a smoker. The nurse stated Patient #10 verbalized financial difficulties and refused to return to the hospital. The comprehensive assessment documented the nurse contacted Patient #10's physician and wrote "Verbal Order obtained," but the details of the order and of the conversation with the physician were not noted.</p> <p>b. A SN visit note, dated 1/30/14 at 4:30 PM, the LPN documented Patient #10 told her he had a bowel movement at 3:00 AM in the recliner, and remained soiled until the LPN visit, more than 13 hours later.</p> <p>c. A PT visit note, dated 2/04/14, from 10:01 AM to 11:13 AM, documented Patient #10 had been instructed by his physician to stop taking Prednisone and Norco. The PT visit note did not</p>	G 143	<p>Clinical staff was educated regarding specific findings from this survey on 3/12/13 at staff meeting. Review of AA-002-13-g Initial Referral and Admission Process (appendix I) with clinicians educating them that they must notify the physician upon completion of the comprehensive assessment to confirm orders.</p> <p>TX-002 Coordination of Care was reviewed with all clinical staff on 3/12/14 in regard to notifying the physician, as well as case manager, clinician manager or DOO. Special emphasis was placed on section 9 of the policy as outlined in TX-002 (Appendix H).</p> <p>Medication management has been reviewed with all clinicians in regard to the necessary follow up in the event the patient verbalizes a change in the medication regimen currently on the plan of care. MA-003 page 2 (appendix J) explains the process the clinicians are to complete every visit and the follow through process if a new, changed or discontinued medication is reported or found.</p>		

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G 143	<p>Continued From page 8</p> <p>include notification to the RN Case Manager of his medication changes. The therapist documented Patient #10 had remained in his recliner for the last 4 days without getting up.</p> <p>d. A SN visit just an hour after the therapy visit on 2/04/14, from 12:30 PM to 1:00 PM, the LPN also documented Patient #10 remained in his recliner. She noted he told her it took 2 people to help get him up and out of the recliner. The LPN stated she reported her visit findings to another nurse (who was not the RN Case Manager for Patient #10). There was no documentation the therapist and the LPN coordinated care activities to facilitate Patient #10's mobility out of his recliner.</p> <p>e. A PT visit note dated 2/06/14, the therapist noted Patient #10 continued to take Norco for pain. On 2/04/14 the therapist wrote the medication had been discontinued by Patient #10's physician. There was no documentation of communication with Patient #10's physician or his RN Case Manager to clarify the Norco had been discontinued and restarted.</p> <p>During an interview on 2/21/14 beginning at 11:45 AM, Patient #10's RN Case Manager reviewed the record and confirmed Prednisone and Norco were documented as being discontinued. He stated he was not informed they had been discontinued. The Case Manager confirmed Patient #10 was in his soiled recliner for a long period of time. The Case Manager stated he was aware Patient #10 continued to drink alcohol and smoke while confined to his recliner, and confirmed he was at risk regarding his safety. The Case Manager confirmed the agency staff did not coordinate the visits to ensure he was assisted out of his recliner for adequate nursing</p>	G 143	<p>At staff meeting, the survey results where no documentation appeared in the patient file regarding issues where the patient appeared to need a greater degree of assistance were reviewed in detail. AA-005 Assessment for Abuse/Neglect (appendix K) was reviewed regarding intervention of staff in the event of possible neglect. All clinicians will take the course on our learn center #5080033 Elder Abuse and Neglect for the skilled clinician. (Appendix L). Course will be completed by 4/1/14.</p> <p>Review of coordination documentation reviewed with all staff. Presently, the staffs send emails in our company email to communicate findings from one clinician to the other. These emails are not to be part of the patient record and these emails must be put on clinical note addendums to have documentation of the coordination and communication between staff members as outlined in IM-008-7 Clinical Record. (Appendix E) The clinicians have been educated to ensure all of their coordination is</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER			STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709		
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G 143	<p>Continued From page 9 assessments and therapy Interventions.</p> <p>The agency did not ensure all disciplines coordinated care activities for Patient #10.</p> <p>2. Patient #9 was a 72 year old male admitted to the agency on 12/06/13, following hospital discharge related to sepsis and cellulitis of his right thigh. Additional diagnoses included osteoarthritis, insulin dependent diabetes and COPD. A referral for therapies, wound care, and diabetic management was received by the agency on 12/05/13.</p> <p>a. In notes from the SOC comprehensive assessment dated 12/06/13, the RN documented Patient #9's spouse was his primary caregiver. She was unable to provide care due to weakness and lower back complications. Additionally, the RN documented Patient #9 was confused and demanded his wife take care of him.</p> <p>In the section of the SOC comprehensive assessment titled "COORDINATION OF CARE," the RN did not note communication with other members of Patient #9's health care team. However, there was notation that verbal orders were obtained on 12/06/13. The notation did not state what the orders included, or the name of the physician who the RN spoke with and received orders from. The comprehensive assessment dated 12/06/13, was a Friday. The RN documented he was at Patient #9's home from 4:42 PM until 7:04 PM.</p> <p>During an interview on 2/21/14 beginning at 1:00 PM, the RN who had performed the SOC comprehensive assessment reviewed Patient #9's record and stated he was unsure, but may</p>	G 143	<p>documented in the patient record to include who they communicated with and what was communicated.</p> <p>It is the care center policy AA-002 Initial Referral/Admit Process (appendix I) that a report is called into the clinical manager on every admission to discuss the clinical case. The clinical manager then initiates the care coordination form documenting report from the various disciplines as they call in report. This form is brought to patient care conference on a weekly basis for further discussion and coordination of care. The form is a paper form and kept in the patient's clinical record. All disciplines attend patient care conference weekly. The clinical manager will be educated as to the type of documentation that is required upon report and follow up with MD as necessary.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 143	<p>Continued From page 10</p> <p>have waited until 12/09/13 to speak with the physician. The RN stated he was unsure if he informed the physician or other members of the health care team about Patient #9's mobility limitations and the inability of his wife to provide for his needs.</p> <p>b. Notes from a PT evaluation dated 12/09/13, described Patient #9 as unable to stand, transfer or walk. The therapist stated Patient #9's wife was his primary caregiver. The notes further stated his wife was overwhelmed and unable to provide for his care. The therapist documented Patient #9 was unable to comprehend and understand or follow commands.</p> <p>The section of the PT evaluation titled "COORDINATION OF CARE," the therapist documented "Physician," followed by a name other than the physician noted as the attending physician on the POC. The record did not include documentation of communication with other members of Patient #9's health care team.</p> <p>During an interview on 2/21/14 beginning at 9:20 AM, the Therapist who performed the PT evaluation on 12/09/13, reviewed Patient #9's record. He confirmed he did not notify Patient #9's physician or the RN Case Manager of the caregiver's inability and reluctance to provide for his safe care. The Therapist stated in the "COORDINATION OF CARE" section of the evaluation, he wrote down the name of the physician who had signed the referral to home health services on 12/05/13. The Therapist confirmed the physician he listed was not Patient #9's attending physician, but the hospitalist who provided inpatient care to Patient #9. The Therapist stated he did not actually speak with</p>	G 143	<p>All clinicians routinely call out reporting all visits completed for the day. They will now be responsible for speaking to the clinical manager to discuss any changes or missed visit that is not going to be made up in the week. The clinical manager will ensure the patient is followed up as needed regarding the missed visit. The report is run daily to determine any missed visits and the DOO will follow up with any visits that were missed and not called in to the clinical manager.</p> <p>Monitoring process: Patients with a change in condition, status or fall will be discussed at weekly patient care conference and follow up will be documented on care coordination forms and filed into patient records. At time of conference, DOO or designee will look at patient file to ensure orders are written and process for meeting</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 143	<p>Continued From page 11</p> <p>any member of Patient #9's health care team, including his physician to discuss his status and POC.</p> <p>c. Notes from an OT evaluation dated 12/09/13, documented "Pt requires extensive care-- more than spouse can manage at present. Pt would benefit from SNF secondary to his deficits."</p> <p>Patient #9's record did not include documentation members of the health care team was notified of the inability of Patient #9's spouse to provide for his safe care.</p> <p>During an interview on 2/21/13 beginning at 1:00 PM, the RN Case Manager reviewed Patient #9's record and confirmed the members of the health care team had not been notified of Patient #9's condition or safety risk.</p> <p>d. Notes from a MSW evaluation dated 12/10/13, documented firemen were assisting Patient #9 out of bed. The MSW stated Patient #9's family was unable to transfer him due to his size and weight. The MSW documented Patient #9 was "Unsafe in home, needed SNF."</p> <p>Patient #9's record did not include documentation his physician or other members of the health care team were notified of the inability of his family to provide for his safe care.</p> <p>During an interview on 2/21/13 beginning at 1:00 PM, the RN Case Manager reviewed Patient #9's record and confirmed the members of the health care team had not been notified of Patient #9's condition or safety risk.</p> <p>e. "A Missed Visit" report, for a missed nursing</p>	G 143	<p>patient's changing needs are occurring. Additionally, these issues are identified on utilization review audits. These audits will be conducted on 20% of open and or closed patient records. Once significant compliance is demonstrated, the DOO or designee will continue the audit of 10% of patient records. The results of these audits will be reported to the PI committee and any problems identified will be addressed at the PI meeting held quarterly. The findings will be discussed at the weekly AVP/DOO meeting.</p> <p>Completion date: 4/1/14</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 143	<p>Continued From page 12</p> <p>visit on 12/10/13, noted Patient #9's spouse cancelled the nursing visit as she was thinking of sending him to the Emergency Room. There was no further documentation of Patient #9's status to indicate why he would be going to the ER.</p> <p>Patient #9's record documented he was hospitalized on 12/12/13.</p> <p>During an interview on 2/21/13 beginning at 1:00 PM, the RN Case Manager confirmed Patient #9's physician had not been informed of the evaluation results from PT, OT, and MSW. He confirmed the spouse was unable to provide for Patient #9's safe care, and his need for a higher level of care that could not be provided in his home environment. Additionally, the RN confirmed he did not notify Patient #9's physician of the missed nursing visit 12/10/13.</p> <p>Communication between members of Patient #9's health care team did not ensure effective coordination of care.</p> <p>5. Patient #14 was a 52 year old female admitted to the agency on 1/29/14, for SN, PT, OT, MSW and HHA services. She was discharged from the hospital on 1/28/14 following a traumatic fracture to her left leg. Additional diagnoses included chronic skin ulcers, Type II DM, depressive disorder and hypertension. Her record and POC for the certification period 1/29/14 to 3/29/14 were reviewed.</p> <p>Patient #14's record included orders she was not to bear weight on her left leg due to the fracture. An OT visit note dated 2/14/14, included documentation Patient #14 was noted to be weigh</p>	G 143			

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G 143	Continued From page 13 bearing on her left leg when she transferred and ambulated with her walker. There was no documentation the RN Case Manager was notified regarding Patient #14's inability to remain non-weight bearing on her left leg.  The OT was interviewed on 2/21/14 at 2:20 PM. She reviewed the record and confirmed she did not communicate with the RN Case Manager regarding Patient #14's non compliance with weight bearing status.	G 143			
G 144	Coordination of care did not occur between Patient #14's Case Manager and her OT. 484.14(g) COORDINATION OF PATIENT SERVICES  The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.  This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the agency failed to ensure care coordination was documented for 4 of 16 patients (#13, #14, #15, and #16) whose records were reviewed. This had the potential to result in unmet patient needs. Findings include:  1. Patient #16's medical record documented a 94 year old female who was admitted for home health services on 11/23/13. She was currently a patient as of 2/21/14. Her diagnoses included muscle weakness and difficulty walking.	G 144	G 144 Coordination of care. The clinical record or minutes from patient care conference will establish that an effective interchange, reporting and coordination of patient care does occur.  The DOO or designee will be responsible to correct this deficiency and ensure ongoing compliance.		

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G 144	<p>Continued From page 14</p> <p>Patient #16's medical record included an order, dated 1/22/14 but not timed, stating "MSW to evaluate patient week of 1/20/14. The evaluation was not conducted until 1/31/14, however. The reason for the delay was not documented in the medical record.</p> <p>Following the MSW order, nursing visits were documented to Patient #16 on 1/23/14, 1/28/14, 1/30/14, 2/04/14, 2/11/14, 2/14/14, and 2/18/14. PT visits were documented on 1/22/14, 1/23/14, 1/27/14, 1/29/14, 1/31/14, 2/03/14, 2/05/14, 2/07/14, 2/10/14, 2/14/14, 2/11/14, 2/14/14, and 2/18/14. MSW visits were documented on 1/31/14, 2/05/14, 2/12/14, and 2/18/14. No coordination of care was documented between the disciplines from 1/22/14 on.</p> <p>The MSW was interviewed on 2/21/14 beginning at 2:25 PM. She stated she spoke with other staff members about Patient #16 but she confirmed this was not documented.</p> <p>Patient #16's Physical Therapist was interviewed on 2/21/14 beginning at 3:35 PM. He stated sometimes Patient #16 appeared unable to do anything for him and some times she would get up and walk with minimal prompting. He stated he spoke with the MSW about whether Patient #16 was ill or whether her lack of participation was behavioral. He confirmed communication between disciplines was not documented.</p> <p>Coordination of care was not documented.</p> <p>2. Patient #15 was an 87 year old female admitted to the agency on 1/06/14, for SN, PT, OT, MSW and HHA services related to methicillin resistant pneumonia, muscle weakness, atrial</p>	G 144	<p>The process for ensuring patient care is coordinated with the DOO or clinical designee beginning with the start of care visit. As outlined in AA-002 Initial Referral/Admit Process, #13 f-k. (Appendix I) Clinicians are to call DOO or clinical designee to give a clinical report and also communicate verbal orders received for admission. The DOO documents the report and the orders on the clinician admit sheet and care coordination form. Copies of the updated clinician admit forms are distributed to each clinician assigned to see that patient prior to delivering care. The care coordination form is brought to the next patient care conference for further discussion of this patient with all disciplines present. All updates are added to the form and then filed into the patient record. All clinicians were educated regarding the documentation required to adequately communicate to the MD and DOO and case managers.</p>		

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G 144	<p>Continued From page 15</p> <p>fibrillation and pressure ulcer stage I. Her medical record and POC for the certification period 1/06/14 through 3/06/14 were reviewed.</p> <p>The LPN visit notes dated 1/13/14, 1/17/14 and 1/20/14, documented Patient #15 reported epistaxis (bleeding from the nose). There was no documentation to indicate Patient #15's RN case manager had been notified of the epistaxis.</p> <p>The Clinical Manager was interviewed on 2/20/14 beginning at 1:30 PM. She stated, staff would email or call in their findings. She confirmed there was no documentation to indicate Patient #15's RN case manager had been notified.</p> <p>Patient #15's RN case manager was not updated about a change in her condition.</p> <p>3. Patient #13 was an 82 year old female admitted to the agency on 1/12/14, with diagnoses pressure ulcer stage III, muscle weakness, hypertension, and colon cancer. Her medical record and POC for the certification period 1/12/14 through 3/12/14, were reviewed.</p> <p>The LPN visit notes, dated 1/22/14, 1/28/14, 2/03/14, 2/10/14, and 2/17/14, documented coordination of care section of the medical record, documented "Clinical Manager." There was no documentation to indicate Patient #13's RN case manager had been notified of any issues or needs.</p> <p>The Clinical Manager was interviewed on 2/20/14 beginning at 1:30 PM. The coordination of care section of the medical record, documented "Clinical Manager." She stated, staff would email or call in their findings. She confirmed there was</p>	G 144	<p>DOO maintains a patient care conference binder containing all of the reports worked for the conference as well as the notes taken during the conference. An attendance sheet is completed for each conference documenting the disciplines present at the conference.</p> <p>The process for scheduling an evaluation visit will be reviewed with all scheduling staff, the clinicians and the clinical managers. The clinicians are to call in the report after admitting a patient for service with their frequency of orders received by the MD. The clinical manager completes a calendar for those visits and gives the calendar to the scheduler to be put in the system. The clinicians are to call the same day of the evaluation whenever possible. The schedulers will schedule all visits on the calendars at least daily. The business office manager will run the scheduled versus actual visit report daily and follow up on any missed visit that was not rescheduled. The schedulers are not to remove a visit from the schedule without documentation as to why that visit was missed and notify the MD if</p>		

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G 144	<p>Continued From page 16</p> <p>no documentation to indicate Patient #13's RN case manager had been notified of any issues or needs.</p> <p>Patient #13's RN case manager was not updated about a change in her condition.</p> <p>4. Patient #14 was a 52 year old female admitted to the agency on 1/29/14, for SN, PT, OT, MSW and HHA services. She was discharged from the hospital on 1/28/14 following a traumatic fracture to her left leg. Discharge medications included Enoxaparin Sodium Injections twice daily for prevention of blood clots. Additional diagnoses included chronic skin ulcers, DM Type II, depressive disorder and hypertension. The POC and medical records for Patient #14's certification period 1/29/14 to 3/29/14 was reviewed.</p> <p>a. The SOC assessment was completed by the RN on 1/29/14. The medication list on the POC Included Enoxaparin Sodium(Generic for Lovenox)120 mg Subcutaneous every 12 hours effective 1/29/14, Discontinue 2/05/14.</p> <p>The SOC assessment documented: "Patient has not picked up her Lovenox, Nystatin or Sulfadiazine." There was no documentation in the record to indicate the RN Case Manager was informed of the missing medications.</p> <p>3 SN visits were completed by the RN Case Manager or an LPN during the time the Patient #14 was to be taking Lovenox, (1/30/14, 2/03/14, and 2/05/13.) There was no documentation in the 3 SN visit notes to indicate the patient had obtained the drug. There was no documentation related to education of the drug.</p>	G 144	<p>that had not been completed by the clinician.</p> <p>The staff will be educated regarding the copying of their email to a clinical note addendum to ensure the coordination of care is documented and becomes a part of the patient record.</p> <p>All clinicians were notified that it is not acceptable to utilize only the checkbox indicating there was coordination. They must include what was communicated to whom as part of the coordination of care. The LPNs were instructed they must document communication with the case manager. If they are not available and the communication is with the clinical manager, it becomes her responsibility to ensure that message is passed on to the case manager when they become available and that effort is documented in the patient record.</p> <p>All clinicians were educated that if a medication was not present on admit or any other time they have an order for a new med, the MD, case manager and clinical manager must be notified.</p>		

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G 144	<p>Continued From page 17</p> <p>The RN Case Manager was interviewed on 2/21/14 at 3:20 PM. She stated she wasn't sure whether the patient had been on Lovenox, then looked at the record in her laptop, and stated she had no knowledge of Lovenox for Patient #14. When asked if she had received report on the patient from the SOC RN she was unable to recall, but stated the SOC RN usually sends a report by email.</p> <p>The SOC RN was interviewed on 2/21/14 at 4:10 PM. She stated she was sure she gave a verbal report to the RN Case Manager. She also stated the patient had taken Lovenox in the past so she did not require education regarding the medication. The RN reviewed the record and confirmed there was no documentation of communication with the RN Case Manager in Patient #14's record.</p> <p>There is no documentation of coordination of care between the SOC RN and the Case Manager.</p> <p>b. The LPN completed the SN visits for Patient #14 on 2/05/14 and 2/12/14.</p> <p>On each visit note, under the Coordination of Care section, the LPN checked "SN" and "Other" and typed in "Clinical Manager."</p> <p>There was no documentation to indicate what information was communicated to the SN and Clinical Manager.</p> <p>The CM was interviewed on 2/24/14 at 10:10 AM. She stated the clinicians often call or email her to communicate information regarding patients. She reviewed the patient's record and confirmed</p>	G 144	<p>Monitoring process: The DOO will meet with the BOM daily for the remainder of March and April to discuss any outstanding missed visits. If significant compliance is met, meetings will decrease to weekly ongoing.</p> <p>Random home visits will be completed by the DOO or clinical manager or designee.</p> <p>The DOO or clinical designee will audit 20% of active and discharge charts emphasizing care coordination areas in the audits. Once significant compliance is demonstrated, the DOO or designee will continue the audit of 10% of patient records. The results of these audits will be reported to the PI committee and any problems identified will be addressed at the Quarterly PI meetings held quarterly. The findings will also be discussed on the weekly AVP call as indicated.</p> <p style="text-align: right;">Completion date: 4/1/14</p>	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137000	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/24/2014
NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER			STREET ADDRESS, CITY, STATE, ZIP CODE 9100 WEST BLACK EAGLE DRIVE BOISE, ID 83709		
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G 144	Continued From page 18 there was no documentation stating what information was communicated. The RN Case Manager confirmed there was no process in place to document the communication or coordination of care.	G 144	G 145 A written summary report for each patient will be sent to the attending physician at least every 60 days.		
G 145	The clinical record did not include documentation regarding coordination of Patient #14's care. 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 1 of 3 patients (#8) who received home health services for more than 1 certification 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:  1. Patient #8 was a 79 year old female admitted to the agency on 11/10/13 for SN and HHA services related to wound care and monitoring her blood for PT/INR related to Coumadin therapy. Additional diagnoses included ESRD, Type II DM, HTN, CKD, and peritoneal dialysis.  a. A recertification assessment for Patient #8's second certification period from 1/09/14 through 3/09/14 was performed on 1/06/14. Her record did not include documentation a 60 day summary	G 145	Patient #8 patient record does contain a 60 summary. It is signed and returned from the MD although that is not required, it is evidence that we sent the summary to the physician. We must have failed to provide you with that documentation.  The DOO is responsible to ensure ongoing compliance to this standard.  Monitoring Process: The DOO or clinical designee will audit 20% of active and discharge charts emphasizing the 60 day summary of progress being sent to the MD. Once significant compliance is demonstrated, 10% of records will be reviewed. The results of these audits will be reported to the PI committee and any problems identified will be addressed at the Quarterly PI meetings held quarterly. The findings will also be discussed on the weekly AVP call as indicated.  Completion date: 4/1/14		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 145	Continued From page 19 was provided to her physician.  During an interview on 2/21/14 beginning at 11:45 AM, Patient #8's RN Case Manager reviewed her record and confirmed that a 60 day summary was not sent to her physician.  The agency did not ensure Patient #8's physician was provided a summary of her progress during the certification period.	G 145			
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  This CONDITION is not met as evidenced by: Based on observation, staff and patient interview, and review of clinical records and agency policies, it was determined the agency failed to ensure systems to plan for care and supervise the medical care of patients were implemented. This resulted in a lack of care direction to agency personnel. Findings include:  1. Refer to G158 as it relates to the agency's failure to ensure the care of patients followed written POCs.  2. Refer to G159 as it relates to the agency's failure to ensure POCs covered all pertinent diagnoses.  3. Refer to G160 as it relates to the agency's failure to ensure the physician approved the POC.  4. Refer to G164 as it relates to the agency's	G 156	G 156 This Condition will be met by agency to ensure the governing body provides direction and oversight to the agency. The corrective action plan will be outlined in each specific tag areas G 158, G 159, G 160, G 164, and G 166.		

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

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G 156	Continued From page 20 failure to ensure professional staff promptly alerted the physician to changes in patients' condition that suggested a need to alter their POCs.	G 156			
G 158	5. Refer to G166 as it relates to the agency's failure to ensure verbal orders were put into writing.  The cumulative effect of these negative systemic practices impeded the agency in providing quality care in accordance with established POCs. 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 agency policies, patient records, and staff interview, it was determined the agency failed to ensure care followed a physician's written POC for 6 of 16 patients (#4, #5, #6, #7, #14 and #16) whose records were reviewed. This resulted in unauthorized treatments, as well as omissions of care and had the potential to result in negative patient outcomes. Findings include:  1. Patient #14 was a 52 year old woman admitted to the agency on 1/29/14, after a hospital discharge following a traumatic fracture to her left leg. In the SOC visit note on 1/29/14, the RN noted the patient had 2 lesions on her abdomen.	G 158	G158 The agency will follow a written plan established by the physician of care for each patient as outlined in AA-014 Plan of Care Process, TX-001 Physician Orders and WC-001 Wound Care Documentation (appendix M-Mc).  The DOO or designee will be responsible for correcting this deficiency and ensuring ongoing compliance to the regulation.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 158	<p>Continued From page 21</p> <p>a. The Plan of Care signed by the physician for the certification period 1/29/14 to 3/29/14 included the following orders "SN to measure/record wound dimensions weekly."</p> <p>-An agency policy titled "Wound Care Reference/Resources/Documentation," dated 7/2013, indicated wound measurements would be performed at a minimum frequency of once each calendar week.</p> <p>-Wound measurements were documented in the SN SOC visit note on 1/29/14. Subsequent SN visits on 1/31/14, 2/03/14, 2/05/14, 2/07/14, 2/12/14 did not contain documentation of wound measurements.</p> <p>b. The Plan of Care signed by the physician for the certification period 1/29/14 to 3/29/14 included the following orders "SN to perform wound care to abdominal wounds, remove dressing, cleanse with wound cleanser or normal saline, pat dry, apply mepilex border. If drainage is moderate/severe may apply silver impregnated dressing under mepilex dressing."</p> <p>- On 1/30/14, the RN documented the patient applied silvadene and a foam dressing with tape to the patient's abdominal wounds. There was no documentation the RN cleansed the wounds. The nurse did not document the application of mepilex. Additionally, the nurse did not indicate the wound drainage amount and if silver impregnated dressing was needed.</p> <p>-On 2/03/14, the LPN documented she applied Silvadene 1%, foam covering and tape to the</p>	G 158	<p>The findings of this survey were presented to the clinicians at the staff meeting held 3/12/14 by the Regional Director of Operations. For those orders that are qualifiable, it was reviewed that the qualifying documentation must be present. The example is when to use one dressing over another when orders for wound care change with an increase in drainage. There must be documentation the drainage was increased to use the specific dressing. The cleansing of the wound must be documented if it was performed or it is assumed that it was not completed. This standard was reviewed again with the nursing staff by the DOO on 3/18/14. The clinicians were educated on how to visualize the orders on their laptops prior to the creation of the 485. Prior to transmission of the visit, the clinicians will have the admit clinician form on paper with the updated orders by the clinical manager as described in AA-002-13-j Initial Referral/Admit Process (appendix I). Adhering to the MD order and proper documentation was reviewed with the clinicians on 3/12/14 and again with only nurses on 3/18/14. Each clinician is responsible</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 158	<p>Continued From page 22</p> <p>abdominal wounds. Silvadene was not included in the wound orders. There was no documentation the LPN cleansed the wounds. The nurse did not document the application of mepilex. Additionally, the nurse did not indicate the wound drainage amount and if silver impregnated dressing was needed.</p> <p>-On 2/05/14, the RN documented wound care was done by the patient. There was no documentation the nurse cleansed the wounds. The nurse did not document the application of mepilex. Additionally, the nurse did not indicate the wound drainage amount and if silver impregnated dressing was needed.</p> <p>-On 2/07/14, the RN documented the patient applied ointment to the abdominal wound. The application of "ointment" was not part of the POC for Patient #14's wound. There was no documentation the nurse cleansed the wounds. The nurse did not document the application of mepilex. Additionally, the nurse did not indicate the wound drainage amount and if silver impregnated dressing was needed.</p> <p>-On 2/12/14, the LPN documented she applied Silvadene 1% to the abdominal wounds. Silvadene was not included in the wound orders. There was no documentation the nurse cleansed the wounds. The nurse did not document the application of mepilex. Additionally, the nurse did not indicate the wound drainage amount and if silver impregnated dressing was needed.</p> <p>During an interview on 2/21/14 at 4:10 PM, the RN who provided the SOC visit stated she did not perform wound care because she did not yet have specific wound care orders. She stated she</p>	G 158	<p>to look at the orders and follow them as specified on every visit. Regional WOCN will provide in-services to the nursing staff on 3/19/14 and 3/20/14. (Handouts- appendix N). Weekly wound measurements will be included in the education as it is our policy. The clinicians were instructed to document the reason no wound care was performed if orders for the wound care were obtained after the visit was completed. This will be documented on the note or a clinical note addendum. Orders obtained after the visit should have an effective date the day the physician ordered the care to be initiated. Care of JP drain will be included in education provided by the Regional WOCN week of 3/17/14.</p> <p>The Regional WOCN will be attending the nursing meetings remotely to discuss all wound care patients to ensure orders have been followed, wounds have been measured weekly and wound care remains the appropriate care to continue. This will begin the week of 3/24/14.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 158	<p>Continued From page 23</p> <p>called the physician to obtain orders later that day after the visit was completed. The RN explained her process of obtaining physician orders and the development of the POC. She stated that after speaking with the physician, the orders were included on the form titled "SN Orders and Goals" and automatically populated from the "SN Orders and Goals" form onto the POC, and that was then sent to the physician.</p> <p>During an interview on 2/21/14, beginning at 2:30 PM, a different RN who did SN visits on 1/30/14, 2/5/14 and 2/7/14 stated she did not know what the wound care orders were because the POC was not visible to her on her laptop. She stated there was no documentation in the patient's home related to wound care. The RN confirmed she provided wound care without knowing the physician's order. She reviewed the record and confirmed she did not measure and record wound measurements weekly. The RN who provided care to Patient #14 stated she was not able to view the POC until it had been finalized and printed.</p> <p>The POC had a computerized date stamp which indicated it was finalized and printed on 2/12/14.</p> <p>During an interview with the Clinical Manager on 2/21/14 at 4:10 PM, she confirmed the wound care was not performed as ordered on the POC. Additionally, the CM confirmed Patient #14's wounds were not measured and recorded as per agency policy and POC.</p> <p>Patient #14's wound care did not follow the physician directed POC.</p> <p>2. Patient #5 was an 82 year old woman</p>	G 158	<p>The process for scheduling a post hospital visit will be no later than 48 hours after the orders have been received. In the event therapies are added, they will be seen within 72 hours unless the MD or patient specifies a date. Policy AA-003 Patient Assessment/Reassessment (appendix F) will be reviewed with all clinicians.</p> <p>The process for scheduling an evaluation from a verbal order will be reviewed with the business office manager, the clinical manager and the schedulers by the DOO and or the Regional Director of Clinical Operations.</p> <p>158 #6 patient #7. We must have failed to supply you with the appropriate documentation as the signed MD orders for therapy were in the patient record. (Appendix N)</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 158	<p>Continued From page 24</p> <p>admitted to the agency for PT and OT services on 2/01/14, following a surgical repair of her fractured shoulder. Additional diagnoses included pressure ulcers and insulin dependent DM.</p> <p>The POC for the certification period 2/01/14 to 4/01/14 included direction for the therapist to perform a diabetic foot inspection each visit.</p> <p>Four PT visits were completed, on 2/01/14, 2/04/14, 2/06/14 and 2/11/14, however foot assessments were not documented in any of the therapy visit notes.</p> <p>During an interview on 2/21/14 at 11:05 AM, the physical therapist confirmed he did not perform diabetic foot assessments during his visits.</p> <p>Patient #5's POC was not followed.</p> <p>3. Patient #6's medical record documented an 87 year old female who was admitted for home health services on 11/07/13. She was currently a patient as of 2/21/14. Her diagnoses included breast cancer and pleural effusion.</p> <p>Transfer papers from a local hospital documented Patient #6 was hospitalized from 1/24/14-1/31/14 for a massive lung infection. Orders from the hospital faxed to the agency on 1/31/14 called for resumption of care by the home health agency. The orders included nursing, PT, and OT services.</p> <p>The first nursing visit to Patient #6 was dated 2/05/14, 5 days after the order was received. The first PT visit was documented on 2/12/14, 12 days</p>	G 158	<p>Monitoring process: Frequencies will be monitored daily by the schedulers at the time of "call off". If a visit is not made, the clinician will be asked for a missed visit note and the information will be given to the clinical manager for the appropriate follow up.</p> <p>The DOO or clinical designee will audit 20% of active and discharge charts emphasizing conformance with MD orders as well as timely evaluations. Once significant compliance is realized, 10% of patient records will be audited. The results of these audits will be reported to the PI committee and any problems identified will be addressed at the Quarterly PI meetings held quarterly. The findings will also be discussed on the weekly AVP call as indicated.</p> <p>The DOO or designee will be doing random home visits to ensure clinicians adhere to standard nursing practice guidelines. The DOO or designee will audit 100% of admissions to ensure the MD was notified and further orders were obtained to establish the POC effective for all admissions 3/20/14.</p> <p>Completion date: 4/1/14</p>		

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G 158	<p>Continued From page 25</p> <p>after the order was received. The first OT visit was documented on 2/14/14, 14 days after the order was received.</p> <p>The Clinical Director, an RN, was interviewed on 2/19/14 beginning at 10:05 AM. She confirmed the orders for Patient #6 were not followed.</p> <p>Patient #6's POC was not followed.</p> <p>4. Patient #16's medical record documented a 94 year old female who was admitted for home health services on 11/23/13. She was currently a patient as of 2/21/14. Her diagnoses included muscle weakness and difficulty walking.</p> <p>Patient #16's medical record included an order, dated 1/22/14 but not timed, stating "MSW to evaluate patient week of 1/20/14. An evaluation by the MSW was not documented until 1/31/14, which was the week of 1/27/14. The record did not document why the evaluation was not conducted as ordered.</p> <p>The MSW was interviewed on 2/21/14 beginning at 2:25 PM. She confirmed the order for an evaluation of Patient #106 the week of 1/20/14. She stated she did not know why the evaluation was not conducted as ordered.</p> <p>Patient #16's POC was not followed.</p> <p>5. Patient #4 was an 81 year old female admitted to the agency following a bilateral mastectomy for breast cancer. The POC for the certification period 2/16/14 through 4/16/14 listed Patient #4's principle diagnosis as "AFTERCARE NEOPLASM SURG." Additional diagnoses included Type II DM, and HTN.</p>	G 158			

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

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G 158	<p>Continued From page 26</p> <p>a. Patient #4's SOC initial comprehensive assessment, dated 2/16/14, included documentation physician orders were obtained. The documentation did not include time of the communication with a physician, or the physician's name.</p> <p>Patient #4's record was reviewed on 2/18/14, and a home visit was conducted on 2/19/14 at 11:15 AM. The agency was unable to provide a POC or physician orders before the home visit to observe a RN visit. It was unclear what skilled nursing services were to be provided by the home health agency.</p> <p>The POC was completed and provided to the survey team on 2/20/14.</p> <p>During an interview on 2/20/14 at 8:50 AM, the RN who performed Patient #4's SOC assessment stated he did not obtain verbal orders from a physician. He stated the referral from the hospital dated 2/13/14, was what he considered "orders". The RN stated his process was to perform the assessment, develop a POC, and submit that to the physician for signature. The RN stated he did not generally contact a physician for verbal orders unless there was a problem that needed to be addressed immediately.</p> <p>Nursing care was provided to Patient #4 before a POC was developed, reviewed, and ordered by her physician.</p> <p>b. Patient #4 had 2 Jackson Pratt drains to her bilateral chest wounds. The SN orders included: SN to instruct on all aspects of JP drain management, instruct to strip and empty JP drain</p>	G 158			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 158	<p>Continued From page 27 1-2 times a day.</p> <p>A visit was conducted on 2/19/14 at 11:15 AM, to observe SN services at Patient #4's home. During the visit the RN was observed while providing JP drain care. She stripped the tubes and emptied the drainage in the evacuator bulbs as ordered. She then disconnected the evacuator bulb from the tubing and rinsed it with tap water, then reconnected the bulb to the tubing and compressed it. The SN orders did not include rinsing the JP bulb with tap water.</p> <p>The Lippencott Manual of Nursing Practice Procedure Guideline for portable wound suction included: Carefully remove the plug, maintaining its sterility, empty the contents, clean the opening and the plug with an alcohol sponge, compress the evacuator completely, replace the plug while the evacuator is compressed.</p> <p>Rinsing the evacuator bulb with tap water was not included in the standard nursing practice guidelines.</p> <p>The RN Case Manager was interviewed on 2/24/14 at 10:10 AM. She confirmed rinsing of the JP drain bulb was not standard practice. She stated the RN who completed the SOC assessment should have called the physician to obtain specific orders for management of the JP drains.</p> <p>The RN who completed the SOC assessment was interviewed on 2/20/14 at 8:50. He stated he did not call the physician after he completed the SOC assessment.</p> <p>Patient #4's JP drain management did not follow</p>	G 158			

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

PRINTED: 03/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/24/2014
NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER			STREET ADDRESS, CITY, STATE, ZIP CODE 9188 WEST BLACK EAGLE DRIVE BOISE, ID 83709		
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G 158	<p>Continued From page 28 a POC established by the physician.</p> <p>6. Patient #7 was an 84 year old female admitted to the agency on 1/24/14 for SN services related to therapeutic drug monitoring following a TIA. Additional diagnoses included HTN, muscle weakness, and hypothyroidism.</p> <p>Patient #7's initial assessment, dated 1/24/14 documented physician orders were obtained for PT and MSW services. However, there were no verbal orders written to indicate what the physician orders included. The POC for the certification period 1/24/14 through 3/24/14 did not include PT or MSW services.</p> <p>There was no indication Patient #7 recieved MSW services.</p> <p>During an interview on 2/21/14 at 4:20 PM, the RN who performed Patient #7's initial assessment reviewed the record. She confirmed she recieved verbal orders for MSW and PT services during a phone call to Patient #7's physician. The RN stated the verbal orders she recieved would be included on the POC, and she did not write actual "verbal orders". The RN confirmed Patient #7's POC did not include orders for MSW or PT services. Additionally, she confirmed a MSW visit had not been performed.</p> <p>A PT evaluation was performed on 1/31/14, 7 days after the SOC. Patient #7's record did not include documentation why there was a delay in initiating PT services. The PT evaluation did not include documentation Patient #7's physician was consulted for orders. The evaluation included a narrative note of "Orders for PT services with specific treatments, frequency and duration, see</p>	G 158			

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

PRINTED: 03/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

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G 158	Continued From page 29 PT Care Plan/485." PT orders were not included on the POC (485).  Patient #7 recieved PT visits on 1/31/14, 2/03/14, 2/04/14, 2/06/14, 2/11/14, 2/13/14, and 2/20/14 without verbal or wrliten physician orders.  During an interview on 2/21/14 beginning at 9:00 AM, the Physical Therapist who performed Patient #7's evaluation reviewed her record and confirmed the initial PT visit ocured 7 days after the SOC. He reviewed the POC for Patient #7 and confirmed there were no orders for PT evaluation or subsequent services.	G 158			
G 159	484.18(a) PLAN OF CARE  The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.  This STANDARD is not met as evidenced by: Based on review of patient records and staff and patient interview, it was determined the agency failed to ensure POCs included all pertinent information, including diagnosis and nursing interventions, equipment, wound care instructions and all pertinent treatments for 5 of 16 patients	G 159	G 159 The plan of care developed with the agency staff and MD will cover pertinent diagnosis, nursing interventions, equipment, wound care instructions and all pertinent treatments at a minimum as outlined in TX-001 Physician Orders (appendix M).  The DOO or designee will be responsible to correct this deficiency and ensure ongoing compliance.  At the staff meeting held 3/12/14, DME and supplies cited by the surveyors were reviewed. All clinicians were		

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

PRINTED: 03/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

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G 159	<p>Continued From page 30 (#4, #7, #8, #13, and #16) whose records were reviewed. This had the potential to interfere with the thoroughness and consistency of patient care. Findings include:</p> <p>1. DME was not included on the POC as follows:</p> <p>a. Patient #7 was an 84 year old female admitted to the agency on 1/24/14 for SN and PT services related to a recent TIA. Additional diagnoses included HTN, and neuropathy of both feet.</p> <p>The SOC comprehensive assessment, dated 1/24/14 noted Patient #7 was wearing compression stockings as ordered by her physician, and used BIPAP for sleep apnea. Patient #7's POC, section 14, (DME and Supplies) did not include those items as DME.</p> <p>During an interview on 2/21/14 beginning at 4:20 PM the RN who completed the SOC assessment reviewed Patient #7's record and confirmed the items were not included as DME.</p> <p>Patient #7's POC did not include all DME.</p> <p>b. Patient #4 was an 81 year old female admitted to the agency following a bilateral mastectomy for breast cancer. The POC for the certification period 2/16/14 through 4/16/14 listed Patient #4's principle diagnosis as "AFTERCARE NEOPLASM SURG." Additional diagnoses included Type II DM, and HTN.</p> <p>During a home visit on 2/19/14 at 11:15 AM, Patient #4 stated she followed a strict diet to maintain her diabetic control, and performed a finger stick glucometer test if she felt she needed to. Patient #4 stated glucose test strips were no</p>	G 159	<p>educated that all DME and supplies were to be included on POC. They were all instructed on where to document the supplies and DME to have them pull over on the plan of care. Clinicians were also educated regarding the importance of ensuring the diet and supplies are consistent and accurate as part of the plan of care. The process of where to document allergies in the assessment was reviewed as there is only one area on the form that carries over to the 485.</p>		

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

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FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER			STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709	
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G 159	<p>Continued From page 31</p> <p>longer covered under her Medicare plan, and she did not routinely test her blood glucose. Patient #4 stated she did have a glucometer and knew how to use it.</p> <p>During an interview on 2/20/13 beginning at 8:50 AM, the RN who performed the initial comprehensive assessment on 2/16/14 reviewed Patient #4's record and confirmed he did not include a glucometer on the POC.</p> <p>Patient #4's POC did not include all DME.</p> <p>c. Patient #13 was an 82 year old female admitted to the agency on 1/12/14, with diagnoses pressure ulcer stage III, muscle weakness, hypertension, and colon cancer. Her medical record and POC for the certification period 1/12/14 through 3/12/14, were reviewed.</p> <p>The POC signed by the physician on 1/21/13, documented the DME as incontinent supplies, box of gloves, 4 X 4 sponge's, tape, alcohol wipes, wound care/dressing supplies, and walker.</p> <p>A SN visit note dated 1/13/14, stated, "...oxygen concentrator present in apartment. States that she wears oxygen at night."</p> <p>The oxygen concentrator was not listed on the POC as DME.</p> <p>The Clinical Nurse Manager was interviewed on 2/20/14 beginning at 1:30 PM. She confirmed the POC did not include an oxygen concentrator as DME.</p> <p>Patient #13's POC did not include all DME.</p>	G 159	<p>Monitoring Process: The DOO or designee will review 100% of the 485s before they are sent to the physician for signature. The review will include the diet, all supplies and DME as well as allergies. The DOO or designee will also audit to ensure the plan of care address the diagnosis and services, and treatments as appropriate. If compliance is not met, an immediate in-service with the clinician will be conducted by the DOO or designee. The DOO or clinical designee will audit 10% of active and discharge charts using our utilization audit tool which includes the supplies and DME in the audits. The results of these audits will be reported to the PI committee and any problems identified will be addressed at the Quarterly PI meetings held quarterly. The findings will also be discussed on the weekly AVP call as indicated.</p> <p>Completion date: 4/1/14</p>	

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

PRINTED: 03/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/24/2014
NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER			STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709	
(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 159	<p>Continued From page 32</p> <p>2. The POC did not include patient allergies as follows:</p> <p>a. Patient #8 was a 79 year old female admitted to the agency on 11/10/13 for SN and HHA services related to wound care and monitoring her blood for PT/INR related to Coumadin therapy. Additional diagnoses included ESRD, Type II DM, HTN, CKD, and peritoneal dialysis.</p> <p>A recertification visit dated 1/06/14, performed by Patient #8's RN Case Manager, contained documentation the POC was reviewed with the physician, and orders were received.</p> <p>Patient #8's POC, section 17, (Allergies) stated "NKA," indicating Patient #8 had No Known Allergies. The recertification assessment, dated 1/06/13, indicated Patient #8 had allergies to fenofibrate, ferrous gluconate, gabapentin, and NSAIDS (non-steroidal anti-inflammatory).</p> <p>During an interview on 2/21/14 beginning at 11:45 AM, the RN who had performed the recertification assessment dated 1/06/14, reviewed Patient #8's record and confirmed her POC did not include allergies. The RN stated he recorded Patient #8's allergies on the recertification form, and it was supposed to automatically populate onto the POC. He stated he was unsure why the allergies were not brought forward onto the POC.</p> <p>Patient #8's allergies were not included on her POC.</p> <p>3. The POC did not include accurate nutritional orders as follows:</p> <p>a. Patient #4 was an 81 year old female admitted</p>	G 159		

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

PRINTED: 03/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

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G 169	<p>Continued From page 33</p> <p>to the agency following a bilateral mastectomy for breast cancer. The POC for the certification period 2/16/14 through 4/16/14 listed Patient #4's principle diagnosis as "AFTERCARE NEOPLASM SURG." Additional diagnoses included Type II DM, and HTN.</p> <p>The POC for the certification period 2/16/14 to 4/16/14 noted Patient #4's diet as "regular." The admission comprehensive assessment dated 2/16/14 noted Patient #4 had Type II DM since 1974.</p> <p>During a home visit on 2/19/14 at 11:15 AM, Patient #4 stated she took oral medications as well as injectable medications for her diabetes. Additionally, Patient #4 stated she followed a strict diet to maintain her diabetic control, and had blood tests every 3 months to monitor her hemoglobin A1C levels.</p> <p>During an interview on 2/20/14 at 8:50 AM, the RN who performed the initial comprehensive assessment reviewed Patient #4's record and confirmed he had documented she was on a regular diet. He stated Patient #4 did not inform him she had dietary restrictions to maintain her diabetic control.</p> <p>Patient #4's POC did not include appropriate nutritional requirements.</p> <p>4. Patient #16's medical record documented a 94 year old female who was admitted for home health services on 11/23/13. She was currently a patient as of 2/21/14. Her diagnoses included muscle weakness, diabetes, and difficulty walking.</p>	G 159			

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

PRINTED: 03/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

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G 159	<p>Continued From page 34</p> <p>Patient #16's SOC, dated 11/22/13, stated she was diabetic and her blood sugar ranged from 100-150. A Resumption of Care Assessment, dated 12/26/13, stated she was diabetic and her blood sugar ranged from 86-222. Her POCs for the certification period 11/22/13-1/22/14 and for the certification period 1/21/14-3/21/14 both included diabetes as a diagnosis. Neither POC documented any direction to staff regarding care for her diabetes such as monitoring her blood sugars or examining her feet. The 11/22/13 POC stated she was on a regular diet. The 1/21/14 POC did not include a diet order.</p> <p>The RN Case Manager was interviewed on 2/21/14 beginning at 1:00 PM. He confirmed Patient #16's POC did not address diabetes. He stated he did not think she was diabetic even though she had that diagnosis. He confirmed this was not documented in her record, however.</p> <p>Patient #16's POC did not address her diabetes.</p> <p>5. Patient #1's medical record documented an 88 year old female who was admitted for home health services on 9/13/13 and was discharged on 10/25/13. Her diagnoses included cellulitis of her leg and atrial fibrillation.</p> <p>A referral form titled "Transfer Orders/Instructions," dated 9/10/13, stated to admit Patient #1 for home health care. The orders stated "Transfer Consults: Occupational Therapy evaluation and treatment. Physical Therapy evaluation and treatment. RN eval. for medication management. Transfer Medication Instructions: Adjust Coumadin dose to target INR between 2-3."</p>	G 159			

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

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FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER			STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709	
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G 159	Continued From page 35 On 9/13/13 at 11:00 AM, Patient #1's medical record documented a PT evaluation was conducted and orders were obtained for the therapist to provide services to her for 7 weeks. No orders were obtained for OT visits or nursing visits. No documentation was present in Patient #1's record that she received OT or nursing visits. No documentation was present in Patient #1's record that explained why these services were not provided.  Patient #1's Physical Therapist/Case Manager was interviewed on 2/20/14 beginning at 8:55 AM. He stated he did not know why nursing and OT services were not provided to Patient #1 as was ordered on the referral. He also stated he did not manage Patient #1's Coumadin. He confirmed there was no documentation to explain the discrepancies.  Patient #1's POC did not reflect the services and treatments that were ordered at the time of her referral.	G 159		
G 160	484.18(a) PLAN OF CARE  If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan.  This STANDARD is not met as evidenced by: Based on review of patient records, agency policy and staff interview, it was determined the agency failed to ensure a physician was consulted to approve the plan of care for 3 of 16 patients (#4, #5, and #14) whose records were reviewed. This resulted in plans of care that were	G 160	G 160 The agency will ensure a physician is consulted to approve the plan of care for all patients.	

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

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FORM APPROVED  
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G 160	<p>Continued From page 36</p> <p>developed and initiated without appropriate physician approval. Findings include:</p> <p>An agency policy "Physician Orders and Medical Supervision of the Plan of Care," dated 11/2013, stated "The physician establishes and participates in the Plan of Care by giving a verbal or written order for the initiation of home care services." Additionally, the policy states: "Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist responsible for furnishing or supervising the ordered services."</p> <p>The physician was not consulted to approve additions and modifications to the POC as follows:</p> <p>1. Patient #4 was an 81 year old female admitted to the agency following a bilateral mastectomy for breast cancer. The POC for the certification period 2/16/14 through 4/16/14 listed Patient #4's principle diagnosis as "AFTERCARE NEOPLASM SURG." Additional diagnoses included Type II DM, and HTN.</p> <p>Patient #4's SOC initial comprehensive assessment, dated 2/16/14, included documentation physician orders were obtained. The documentation did not include time of the communication with a physician, or the physician's name.</p> <p>Patient #4's record was reviewed on 2/18/14, and a home visit was conducted on 2/19/14 at 11:15 AM. The agency was unable to provide a POC or physician orders before the home visit. It was unclear what skilled nursing services were to be provided by the home health agency.</p>	G 160	<p>TX-001 Physician Orders and Medical Supervision of the Plan of Care Policy was reviewed with clinicians at staff meeting 3/12/14 and again on 3/13/14. All clinicians must contact the MD after the initial comprehensive assessment and evaluation visits to approve the pan of care. Documentation of this contact will include the communication that took place and the physician's name.</p> <p>The DOO or designee will be responsible to correct this deficiency and ensure ongoing compliance.</p> <p>On patient #5, a copy of signed MD orders approving the plan of care was found in the patient record. We must have failed to provide that to you at the time of your request. (Appendix O) Those visits have not been made non-billable.</p> <p>Monitoring Process: 100% of the initial assessments will be audited by the DOO or designee to ensure the documentation of the physician contact to approve the plan of care is present. If non-compliance is found, an immediate in-service will be held.</p>		

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

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G 160	Continued From page 37  The POC was completed and provided to the survey team on 2/20/14.  During an interview on 2/20/14 at 8:50 AM, the RN who performed Patient #4's SOC assessment stated he did not obtain verbal orders from a physician. He stated the referral from the hospital dated 2/13/14, was what he considered "orders". The RN stated his process was to perform the assessment, develop a POC, and submit that to the physician for signature. The RN stated he did not generally contact a physician for verbal orders unless there was a problem that needed to be addressed immediately.  Nursing care was provided to Patient #4 before a POC was developed, reviewed, and ordered by her physician.  2. Patient #7 was an 84 year old female admitted to the agency on 1/24/14 for SN services related to therapeutic drug monitoring following a TIA. Additional diagnoses included HTN, muscle weakness, and hypothyroidism.  Patient #7's initial assessment, dated 1/24/14 documented physician orders were obtained for PT and MSW services. However, there were no verbal orders written and PT and MSW orders were not included on the POC.  A PT evaluation was performed on 1/31/14, 7 days after the SOC. The PT evaluation did not include documentation Patient #7's physician was consulted for orders. The evaluation included a narrative note of "Orders for PT services with specific treatments, frequency and duration, see PT Care Plan/485." PT orders were not included	G 160		Completion Date: 4/1/14	

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

PRINTED: 03/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/24/2014
NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER			STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709		
(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)	(X6) COMPLETION DATE	
G 160	<p>Continued From page 38 on the POC (485).</p> <p>Patient #7's physician was not consulted for PT orders after the evaluation visit was performed.</p> <p>2. Patient #5 was an 82 year old woman admitted to the agency on 2/01/14, after a hospital discharge following a procedure to repair a fractured shoulder. Additional diagnoses included pressure ulcers, Insulin dependent DM and hypertension. Patient #5's medical record for the certification period of 2/01/14 to 4/01/14 was reviewed on 2/20/14.</p> <p>The SOC comprehensive assessment was completed by the physical therapist on 2/01/14(a Saturday.) The comprehensive assessment included: "...will communicate with physician's office on Monday." The medical record did not include documentation the therapist received orders from Patient #5's physician for therapy services.</p> <p>Patient #5's POC was finalized and printed on 2/20/14 and remained unsigned by the physician as of 2/24/14, the survey exit date.</p> <p>During an interview on 2/21/14 at 11:05 AM, the Physical Therapist stated he always called the physician for orders following his assessment. The therapist reviewed Patient #5's record and confirmed he did not contact the physician. Additionally, he confirmed therapy services to Patient #5 on 2/04/14, 2/06/14 and 2/11/14 were provided without physician orders.</p>	G 160			

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

PRINTED: 03/12/2014  
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G 160	Continued From page 39 Patient #5's physician was not consulted to approve his POC.  3. Patient #14 was a 52 year old female admitted to the agency on 1/29/14, after a hospital discharge following a traumatic fracture to her left leg. Additional diagnoses included chronic skin ulcers, DM Type II, neuropathy, and depressive disorder. Patient #14's record for the certification period 1/29/14 to 3/29/14 was reviewed on 2/19/14.  The SOC comprehensive assessment dated 1/29/14 was completed by an RN. The RN documented a verbal order was obtained, however, there was no further documentation in Patient #14's record of verbal orders. The POC was signed by Patient #14's physician on 2/13/14, 15 days after the SOC.  Nursing visits were provided on 1/30/14, 2/03/14, 2/05/14, 2/07/14 and 2/12/14 without physician orders.  During an interview on 2/21/14 at 4:10 PM, the RN stated she called Patient #14's physician after the initial assessment visit to obtain orders. She confirmed verbal orders were not written, but stated the orders were on the POC, and was instructed by the agency that was sufficient.	G 160		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE  Agency professional staff promptly alert the physician to any changes that suggest a need to	G 164		

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

PRINTED: 03/12/2014  
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OMB NO. 0938-0391

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G 164	<p>Continued From page 40 alter the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on review of agency policies, clinical records, and staff interview, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in patients' condilions that suggested a need to alter the plan of care for 6 of 16 patients (#1, #5, #9, #10, #14 and #15) whose records were reviewed. This resulted in missed opportunity for the physician to alter the POC to meet patient needs. Findings include:</p> <p>An agency policy, titled "Plan of Care," dated 05/2013, included "The physician is notified if the Agency does not provide care and services in accordance with the physician's orders." Nursing staff failed to adhere to the policy as follows:</p> <p>1. Patient #10 was a 67 year old male admitted on 1/20/14 for SN, PT, OT, and MSW services after a fall which resulted in fractures of his lumbar vertebrae. Additional diagnoses included muscle weakness, abnormality of gait, arthritis, smoking, and alcohol abuse.</p> <p>a. In a SN visit note, dated 1/30/14 at 4:30 PM, the LPN documented Patient #10 told her he had a bowel movement at 3:00 AM in the recliner, and remained soiled until the LPN visit, more than 13 hours later. The physician was not notified of Patient #10's inability to provide for his personal hyglene and safety.</p> <p>b. A PT visit note, dated 2/04/14, from 10:01 AM to 11:13 AM, documented Patient #10 had been instructed by his physician to stop taking</p>	G 164	<p>G 164 Agency staff will promptly alert the physician to any changes that suggest a need to alter the plan of care.</p> <p>The DOO or designee will be responsible to correct this deficiency and ensure ongoing compliance.</p> <p>Clinicians were notified of all deficiencies in the report from the State on 3/13/14. The patients identified in the report did have changes in condition, medications, and safety risks without documentation that the MD was notified. Clinicians educated regarding the importance of notification of the MD and documentation of such communication. Education to the staff 3/13/14 included to verify all medication changes reported by a patient of family to validate and add to plan of care. Plans of care will be reviewed by the Clinical Resource Coordinators and then by clinical managers. The staff will be educated regarding the copying of their email to a clinical note addendum to ensure the coordination of care is documented and becomes a part of the patient record.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 164	<p>Continued From page 41</p> <p>Prednisone and Norco. The therapist documented Patient #10 had remained in his recliner for the last 4 days without getting up. The physician was not contacted for verification the medications had been discontinued, or of his inability to get out of the recliner.</p> <p>c. In a PT visit note, dated 2/06/14, the therapist noted Patient #10 continued to take Norco for pain. On 2/04/14 the therapist had noted the medication had been discontinued by Patient #10's physician. There was no documentation of communication with Patient #10's physician or his RN Case Manager to clarify if the Norco had been discontinued and restarted.</p> <p>During an interview on 2/21/14 beginning at 11:45 AM, Patient #10's RN Case Manager reviewed his record and confirmed the medications Prednisone and Norco were documented as being discontinued, however, he stated he had not been informed of that. The Case Manager confirmed Patient #10 had a prolonged time sitting in a soiled recliner, and stated the LPN contacted him that day to assist with his cleaning. The Case Manager stated he was aware Patient #10 continued to drink alcohol and smoke while in his recliner, and confirmed the physician was not notified regarding his safety risk.</p> <p>Patient #10's physician was not notified of changes in his condition which indicated a need to change his POC.</p> <p>2. Patient #9 was a 72 year old male admitted to the agency on 12/06/13, following hospital discharge related to sepsis and cellulitis of his right thigh. Additional diagnoses included osteoarthritis, insulin dependent diabetes and</p>	G 164	<p>All clinicians were notified that it is not acceptable to utilize only the checkbox indicating there was coordination. They must include what was communicated to whom as part of the coordination of care. The job aide on when to refer to a social worker will be distributed to the team next week at Patient Care Conference to ensure all staff knows when to call the MD with a request for the MSW to assist with issues that may be impeding the plan of care. (Appendix P)</p> <p>Clinicians educated regarding the necessary follow up when a patient states they are going to the ER. At a minimum, we are responsible to follow up to see if the patient was admitted or if the plan needs to be altered due to a change in condition.</p> <p>Education to clinicians on 3/13/14 regarding issues of non-compliance that could potentially have a negative impact on the patient's outcomes must be related to the physician and that communication must be documented. Clinicians will be educated regarding</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 164	<p>Continued From page 42</p> <p>COPD. A referral for therapies, wound care, and diabetic management was received by the agency on 12/05/13.</p> <p>a. Notes from a PT evaluation dated 12/09/13, described Patient #9 as unable to stand, transfer or walk. The therapist stated Patient #9's wife was his primary caregiver. The notes further stated his wife was overwhelmed and unable to provide for his care. The therapist documented Patient #9 was unable to comprehend and understand or follow commands.</p> <p>The section of the PT evaluation titled "COORDINATION OF CARE," the therapist documented "Physician," followed by a name other than the physician noted as the attending physician on the POC.</p> <p>During an interview on 2/21/14 beginning at 9:20 AM, the Therapist who performed the PT evaluation on 12/09/13 reviewed Patient #9's record. He confirmed he did not notify Patient #9's physician or the RN Case Manager of the caregiver's inability and reluctance to provide for his safe care. The Therapist stated in the "COORDINATION OF CARE" section of the evaluation, he had written down the name of the physician who had signed the referral to home health services on 12/05/13. The Therapist confirmed the physician's name he wrote down was not Patient #9's attending physician, but the hospitalist who provided inpatient care to Patient #9. The therapist stated he did not actually speak with anyone to discuss Patient #9's status and POC.</p> <p>b. Notes from an OT evaluation dated 12/09/13,</p>	G 164	<p>patient pain levels. Pain at levels 7/10 or greater must be reported to the MD unless other parameters are ordered in the plan of care. This will occur week of 3/25/14 by the DOO or designee. Clinicians will be educated regarding issues such as epistaxis will be reported immediately to MD if a patient is on anticoagulant therapy. Communication will be documented in patient record. All clinicians to be educated to report all falls to the MD whether they are reported or witnessed. An occurrence report is to be completed as well and submitted to the DOO for tracking.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 164	<p>Continued From page 43</p> <p>documented "Pt requires extensive care-- more than spouse can manage at present. Pt would benefit from SNF secondary to his deficits."</p> <p>Patient #9's record did not include documentation his physician was notified of the inability of Patient #9's spouse to provide for his safe care.</p> <p>During an interview on 2/21/13 beginning at 1:00 PM, the RN Case Manager reviewed Patient #9's record and confirmed the physician had not been notified of Patient #9's condition or safety risk.</p> <p>c. Notes from a MSW evaluation dated 12/10/13, documented firemen were present at the time of her visit to assist Patient #9 out of bed. The MSW stated Patient #9's family was unable to transfer him due to his size and weight, and his wife was elderly with back problems. The MSW documented Patient #9 was "Unsafe in home, needed SNF."</p> <p>Patient #9's record did not include documentation his physician was notified of the inability of his family to provide for his safe care.</p> <p>During an interview on 2/21/13 beginning at 1:00 PM, the RN Case Manager reviewed Patient #9's record and confirmed the physician had not been notified of Patient #9's condition or safety risk.</p> <p>d. "A Missed Visit" report, for a missed nursing visit on 12/10/13, noted Patient #9's spouse declined the nursing visit as she was thinking of sending him to the Emergency Room. There was no further documentation of Patient #9's status indicating why he would be going to the ER. There was no documentation Patient #9's physician was notified.</p>	G 164	<p>Monitoring Process: The DOO or clinical designee will audit 20% of active and discharge charts with emphasis on notification of the physician of changes in the patient's condition in the audit tool. Once significant compliance is demonstrated, the DOO or designee will continue the audit of 10% of patient records. Pain is also monitored as well as the intervention regarding the pain. The results of these audits will be reported to the PI committee and any problems identified will be addressed at the Quarterly PI meetings held quarterly. The findings will also be discussed on the weekly AVP call as indicated. The DOO or designee will also perform random home visits to ensure this standard is being met.</p> <p>DOO will review 100% of occurrence reports to ensure all areas are complete and clinicians notified the MD and or altered the plan of care as appropriate.</p> <p>Completion date: 4/1/14</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 164	<p>Continued From page 44</p> <p>e. Patient #9's record documented he was hospitalized on a form titled "Transfer to In-Patient Facility" on 12/12/13.</p> <p>During an interview on 2/21/13 beginning at 1:00 PM, the RN Case Manager confirmed Patient #9's physician had not been informed of the evaluation results from PT, OT, and MSW. He confirmed the caregiver was unable to provide for Patient #9's safe care, and his need for a higher level of care that could not be provided in his home environment.</p> <p>Patient #9's physician was not notified of changes that required an alteration of his POC.</p> <p>3. Patient #14 was a 52 year old woman admitted to the agency on 1/29/14, after a hospital discharge following a traumatic fracture to her left leg. The record for the certification period 1/29/14 to 3/29/14 was reviewed.</p> <p>a. Patient #14's POC stated she was not to bear any weight on her left leg.</p> <p>The PT evaluation was completed on 1/30/14. The documentation noted Patient #14 was non-weight bearing but still put weight on her left lower extremity. There was no indication her physician was notified she was bearing weight on her left leg.</p> <p>During an interview on 2/21/14 at 9:00 AM the physical therapist stated Patient #14 was overweight and he told her she was not to bear weight on her left leg. He confirmed he did not notify Patient #14's physician that she was bearing weight on her left leg.</p>	G 164			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 164	<p>Continued From page 45</p> <p>The OT visit note completed on 2/12/14 stated the Patient #14 continued to require re-enforcement regarding her non-weight bearing status. The OT visit note completed on 2/14/14 stated she was obviously bearing weight during transfer and ambulation with her walker. There was no indication Patient #14's physician was notified she was bearing weight on her left leg.</p> <p>During an interview on 2/21/14 at 2:20 PM the Occupational Therapist confirmed she had not notified the physician that Patient #14 was bearing weight on her left leg.</p> <p>Patient #14's physician was not notified of a change in her condition.</p> <p>b. Patient #14's POC included Norco 10-325 mg to be taken every 6 hours as needed for pain.</p> <p>During an interview on 2/20/14 at 2:30 PM, the CM stated pain levels between 7 and 10 are considered severe and should be reported to the physician, per agency practice.</p> <p>The SOC comprehensive assessment completed by the RN on 1/29/14 stated Patient #14 had taken Norco 2 hours prior to the nurse's visit. The patient rated her pain as 8 on a scale of 0-10 with 10 being the worst pain. The RN documented the pain assessment indicated severe pain. There was no indication Patient #14's physician was informed that her pain was not adequately controlled.</p> <p>During an interview on 2/21/14 at 4:40 PM, the RN who completed the SOC confirmed she did not notify the physician of the Patient #14's level</p>	G 164		

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

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G 164	<p>Continued From page 46 of pain.</p> <p>The SN visit note completed on 1/30/14 stated Patient #14 had taken Norco 4.5 hours prior to the visit. She rated her pain as 7 on a scale of 0-10. There was no indication the physician was informed her pain was not adequately controlled.</p> <p>During an interview on 2/20/14 at 2:20 PM, the RN who completed the visit on 1/30/14, stated she felt the patient was inappropriate in her response. She confirmed she did not contact the physician regarding Patient #14's level of pain.</p> <p>The PT evaluation completed on 1/30/14 stated Patient #14 had taken Norco 3 hours prior to the therapy visit. Her pain was rated as 7 on a scale of 0-10. There was no indication the physician was informed Patient #14's pain was not adequately controlled with her pain medication.</p> <p>During an interview on 2/21/14 at 9:00 AM, the Physical Therapist stated that pain is subjective. He confirmed he did not contact the physician regarding Patient #14's level of pain.</p> <p>The OT evaluation completed on 1/30/14 stated the patient rated her pain as 8 on a scale of 0-10. The patient stated her pain was relieved for 3 hours after taking Norco. Per the POC, the Norco was to be taken every 6 hours as needed. There was no indication the physician was informed the patient's pain was not adequately controlled with her pain medication.</p> <p>During an interview on 2/21/14 at 2:20 PM, the Occupational Therapist stated the patient's pain was increased because she was bearing weight on her left leg against physician's orders. She</p>	G 164			

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

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G 164	<p>Continued From page 47</p> <p>confirmed she did not contact the physician regarding Patient #14's level of pain.</p> <p>Patient #14's physician was not notified of the patient's unrelieved pain that suggested a need to alter the POC.</p> <p>4. Patient #15 was an 87 year old female, admitted to the agency on 1/06/14, for SN, PT, OT, MSW and HHA services related to methicillin resistant pneumonia, muscle weakness, atrial fibrillation and pressure ulcer stage I. Her medical record and POC for the certification period 1/06/14 through 3/06/14, were reviewed.</p> <p>The LPN visit notes dated on 1/13/14, 1/17/14, and 1/20/14, documented Patient #15 reported epistaxis (bleeding from the nose). There was no documentation to indicate Patient #15's physician had been notified of the bleeding.</p> <p>The Clinical Manager was interviewed on 2/20/14 beginning at 1:30 PM. She confirmed there was no documentation to indicate Patient #15's physician had been notified of the epistaxis.</p> <p>Patient #15's physician was not updated about a change in her condition.</p> <p>5. Patient #1's medical record documented an 88 year old female who was admitted for home health services on 9/13/13 and was discharged on 10/25/13. Her diagnoses included cellulitis of her leg and atrial fibrillation.</p> <p>Patient #1's medical record documented she received PT services between 9/13/13 and 10/24/13. On 10/21/13 at 2:00 PM, a "PT VISIT NOTE" documented Patient #1 reported a fall the</p>	G 164			

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

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G 164	Continued From page 48 previous week. No documentation was present that the physician was notified of the fall. On 10/24/13 at 12:00 noon, "PT VISIT NOTE" documented Patient #1's legs had become weak and her balance was poor in response to an antibiotic medication. The note stated Patient #1 had fallen 3 times the day before in which "...she slid off the bed because her legs were too weak to hold her. The note stated the medication had been discontinued but Patient #1 still felt "loopy." The note stated the physician had seen Patient #1 recently but it was not clear if this was before or after the falls. The note stated Patient #1 was "...unable to transfer safely, has fallen three times and is unable to walk safely with support." A form titled "TRANSFER/DEATH AT HOME," written by the Physical Therapist and dated 10/28/14 at 3:00 PM, stated Patient #1 had fallen, had fractured her hip, and was taken to a hospital. The note did not state what day this happened.  Patient #1's Physical Therapist/Case Manager was interviewed on 2/20/14 beginning at 8:55 AM. He stated there was no documentation he had notified the physician of the falls noted on 10/21/13 or 10/24/13.  The Physical Therapist did not notify the physician of Patient #1's condition following her falls.	G 164			
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS  Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.	G 166	G 166 The agency will ensure that verbal orders are put into writing and signed and dated by the clinician.		

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

PRINTED: 03/12/2014  
FORM APPROVED  
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NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER			STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709		
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G 166	Continued From page 49  This STANDARD is not met as evidenced by: Based on record review, staff interview, and patient interview, it was determined the agency failed to ensure verbal orders were put in writing for 1 of 16 patients (#14) whose records were reviewed. This had the potential to negatively impact coordination and clarity of patient care. Findings include:  1. Patient #14 was a 52 year old woman admitted to the agency on 1/29/14, after a hospital discharge following a traumatic fracture to her left leg. Her medications included Coumadin. Patient #14's record for the certification period 1/29/14 to 3/29/14 was reviewed.  A SN visit note dated 2/07/14, stated the RN called the physician's office and obtained a verbal order for a PT/INR to be performed that day. The verbal order was not put in writing and signed and dated by the RN.  During an interview on 2/24/14, the RN Case Manager reviewed the record and confirmed there was no written physician's order for the PT/INR performed on 2/7/14.  The verbal order for PT/INR was not put in writing by the RN.	G 166	The DOO or designee will be responsible to correct this deficiency and ensure ongoing compliance.  Policy TX-001 Physician Orders (appendix M) will be reviewed with clinicians at meeting week of 3/24/14. Emphasis will be on #7 the individual receiving a verbal physician order must sign and document the date of the order on the supplemental order form.  Monitoring Process: The DOO or clinical designee will audit 20% of active and discharge charts to ensure the clinicians have orders for their interventions. The results of these audits will be reported to the PI committee and any problems identified will be addressed at the Quarterly PI meetings held quarterly. The findings will also be discussed on the weekly AVP call as indicated.  Completion date: 4/1/14		
G 236	484.48 CLINICAL RECORDS  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	G 236			

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G 236	<p>Continued From page 50</p> <p>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 staff interview and review of medical records, it was determined the agency failed to ensure medical records were complete, accurate, and contained complete information for 4 of 16 patients (#6, #10, #13, and #15), whose records were reviewed. This resulted in a lack of clarity as to the patients' care from agency personnel. Findings include:</p> <p>1. The agency's medical records consisted of a hybrid paper and electronic medical record. During the survey, the Administrator and the Clinical Manager worked to obtain medical records for surveyors.</p> <p>On 2/20/14 at 9:20 AM, the Administrator stated she had not been trained to reproduce complete medical records for surveyors to review. She stated requests were sent to the corporate office to reproduce complete records.</p> <p>On 2/20/14 at 1:45 PM, the Clinical Manager stated she had not been trained to produce complete medical records. She stated records that were provided to surveyors had not been complete. For example, she stated signed copies of POCs and supplemental orders were not provided with the medical records.</p>	G 236	<p>G 236 The agency will ensure medical records are complete, accurate and contain all necessary information.</p> <p>The DOO and business office manager will be responsible to correct this deficiency and ensure ongoing compliance.</p> <p>Clinical manager, DOO and AVP have been trained as to how to print out a patient chart as outlined in the operation manual and the Policy IM-008 Clinical Records (appendix E)</p> <p>All clinicians and clinical managers will be education the week of 3/24/14 regarding the necessity to document everything in the patient record such as patient refusal of services.</p> <p>Clinicians were educated at the staff meeting regarding the use of ABNs and HHCNs. They were given handouts with algorithms and guides for when to use which form. Additionally, they were tasked with completing the course on our learn center called ABN and HHCCN #2110082. The course will need to be completed by 4/1/14.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 236	<p>Continued From page 51</p> <p>The Area Vice-President was interviewed on 2/24/14 beginning at 10:00 AM. She stated no staff at the agency had been trained to reproduce a complete medical record.</p> <p>The agency failed to ensure complete medical records could be reproduced when needed.</p> <p>2. Patient #6's medical record documented an 87 year old female who was admitted for home health services on 11/07/13. She was currently a patient as of 2/21/14. Her diagnoses included breast cancer and pleural effusion.</p> <p>Transfer papers from a local hospital documented Patient #6 was hospitalized from 1/24/14-1/31/14 for a massive lung infection. Orders from the hospital faxed to the agency on 1/31/14 called for resumption of care by the home health agency. The orders included nursing, PT, and OT services.</p> <p>The first nursing visit to Patient #6 was dated 2/05/14, 5 days after the order was received. The first PT visit was documented on 2/12/14, 12 days after the order was received. The first OT visit was documented on 2/14/14, 14 days after the order was received.</p> <p>The RN Case Manager was interviewed on 2/19/14 beginning at 2:10 PM. She stated she thought Patient #6 refused the services which delayed her resumption of care. She stated this was not documented.</p> <p>Patient #6's medical record was not complete.</p> <p>3. Patient #13 was an 82 year old female, admitted to the agency on 1/12/14, with</p>	G 236	<p>Effective 3/20/14, all wound addendums without a signature will be printed out and given to the clinician for signature until such time the "bug" is fixed and all electronic signatures appear on the form. The forms will be signed and filed in the patient record.</p> <p>Monitoring process: The DOO or clinical designee will audit 20% of active and discharge charts to ensure the clinicians have orders for their interventions. Once significant compliance is demonstrated, the DOO or designee will continue the audit of 10% of patient records. The results of these audits will be reported to the PI committee and any problems identified will be addressed at the Quarterly PI meetings held quarterly. The findings will also be discussed on the weekly AVP call as indicated. The DOO will monitor the completion of the courses and it will become a performance issue if the course is not completed timely.</p> <p>Completion date: 4/1/14</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 236	<p>Continued From page 52</p> <p>diagnoses pressure ulcer stage III, muscle weakness, hypertension, and colon cancer. Her medical record and POC for the certification period 1/12/14 through 3/12/14, were reviewed.</p> <p>The agency policy titled IM-008(a) CLINICAL RECORD CONTENTS, dated October 2013, stated, "All documentation is dated and authenticated by name/signature and title of person making entry."</p> <p>SN visit wound addendum notes, dated 1/22/14, 1/28/14, 2/03/14, 2/10/14, and 2/17/14, did not have documented signatures, titles and dates.</p> <p>The Regional Director of Clinical Operations was interviewed on 2/19/14 at 3:40 PM. She confirmed Patient #13's, medical record included notes that lacked signature, date and title.</p> <p>The agency did not ensure documentation for patient medical records was complete and accurate.</p> <p>4. Patient #15 was an 87 year old female, admitted to the agency on 1/06/14, for SN, PT, OT, MSW and HHA services related to methicillin resistant pneumonia, muscle weakness, atrial fibrillation and pressure ulcer stage I. Her medical record and POC for the certification period 1/06/14 through 3/06/14, were reviewed.</p> <p>A SN visit wound addendum note, dated 1/06/14, did not have documented signature, title and date.</p> <p>The Regional Director of Clinical Operations was interviewed on 2/19/14 at 3:40 PM. She confirmed Patient #15's, medical record included</p>	G 236			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 236	<p>Continued From page 53 notes that lacked signature, date and title.</p> <p>The agency did not ensure documentation for patient medical records was complete and accurate.</p> <p>5. Patient #10 was a 67 year old male admitted on 1/20/14 for SN, PT, OT, and MSW services after a fall which resulted in fractures of his lumbar vertebrae. Additional diagnoses included muscle weakness, abnormality of gait, arthritis, and alcohol abuse.</p> <p>Patient #10's record included a "Notice of Medicare Non-Coverage" form (NOMNC) dated 2/06/14, which notified him that his home health services would end on 2/11/14.</p> <p>In a SN visit note dated 2/06/14, the LPN documented Patient #10 was informed of SN discontinuing services due to goals being met. The LPN documented Patient #10 agreed with the decision to discontinue services, and he was educated, acknowledged, and verbalized understanding of the form, then signed the NOMNC form dated 2/06/14.</p> <p>Patient #10 continued to receive OT and PT visits, OT on 2/12/14 and 2/14/14, and PT on 2/13/14.</p> <p>During an interview on 2/21/14 beginning at 11:45 AM, the RN Case Manager reviewed Patient #10's record and confirmed the record included a NOMNC form. He stated Patient #10 received the wrong form, he should have been provided with a form explaining his nursing services would be discontinued.</p>	G 236		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 236	Continued From page 54 Patient #10 received a wrong form informing him his home health services were terminated, his record did not reflect this was corrected.	G 236			
G 322	484.20(b) ACCURACY OF ENCODED OASIS DATA  The encoded OASIS data must accurately reflect the patient's status at the time of assessment.  This STANDARD is not met as evidenced by: Based on record review and staff and patient interview, it was determined the agency failed to ensure encoded OASIS data reflected the patient's status at the time of assessment for 1 of 16 patients whose records were reviewed (#4). This resulted in inaccuracies between the SOC assessment and OASIS data. Findings include:  Patient #4 was an 81 year old woman admitted to the agency on 2/16/14 for SN services following a bilateral mastectomy for breast cancer. Additional diagnoses included hypertension and DM Type II. The patient's POC and records for the certification period 2/16/14 to 4/16/14 were reviewed.  The SOC assessment including the OASIS was completed by the RN on 2/16/14.  A visit was conducted on 2/19/14 at 11:15 AM, to observe SN services at Patient #4's home.  Information garnered during the home visit was compared to the SOC OASIS data. The following discrepancies were noted:  a. OASIS Item M1018 indicates conditions which existed prior to the patient's inpatient stay.	G 322	G 332 The agency will ensure the encoded oasis data accurately reflect the patient status at the time of assessment.  The DOO or designee will be responsible to correct this deficiency and ensure ongoing compliance.  This deficiency was reviewed with the skilled clinicians on 3/13/14 and will be reviewed again the week of 3/24/14. 100% of oasis are reviewed by either the clinical manager or the Clinical Resource Coordinator (CRC) for accuracy. The CRC was informed of the deficiencies received from the survey. If any discrepancies or inconsistencies are noted, the clinicians are called to discuss findings. If the clinicians want to alter their responses, the CRC or clinical manager will make the changes and an oasis correction form is created and sent to the clinician for approval of the changes. The ledger will maintain the original responses. The patient		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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G 322	<p>Continued From page 55</p> <p>Intractable pain was marked as existing prior to her hospitalization and surgery.</p> <p>Upon interview of Patient #4 during the home visit she denied having any pain prior to her hospitalization for bilateral mastectomies.</p> <p>The SOC RN was interviewed on 2/20/14 at 8:50 AM. He confirmed Patient #4 was having moderate pain following her surgery but denied any pain prior to her surgery.</p> <p>b. OASIS Item M1036 indicates Risk factors likely to affect current health status and/or outcome. Smoking and Alcohol dependency were marked as risk factors.</p> <p>Upon interview of the patient during the home visit the patient denied smoking, stating she quit many years ago.</p> <p>The SOC RN was interviewed on 2/20/14 at 8:50 AM. He confirmed the patient stated she stopped smoking 30 years ago. He stated the patient related an alcohol intake of approximately 3 drinks per week.</p> <p>c. OASIS Item M1340 indicates presence of a surgical wound. The item was answered "Surgical wound known but not observable due to non-removable dressing."</p> <p>Upon interview of the patient during the home visit, the patient stated a dressing was never applied to her chest following surgery due to her severe tape allergy.</p> <p>The SOC RN was interviewed on 2/20/14 at 8:50 AM. He confirmed the patient did not have a</p>	G 322	<p>record will have the oasis that was transmitted to the State and the oasis correction form under the oasis tab of the patient record.</p> <p>Monitoring Process: 100% of oasis will be reviewed by either the clinical manager or the Clinical Resource Coordinator (CRC) for accuracy. Should the CRC or clinical manager notice a trend, the clinician will have further education. The DOO or clinical designee will audit 20% of active and discharge charts ensure oasis is consistent in the responses and accurately reflects the status of the patient. Once significant compliance is demonstrated, the DOO or designee will continue the audit of 10% of patient records. The results of these audits will be reported to the PI committee and any problems identified will be addressed at the Quarterly PI meetings held quarterly. The findings will also be discussed on the weekly</p>		

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G 322	<p>Continued From page 56</p> <p>dressing covering the incision lines on her chest. He stated the patient was resistant to having a male RN observe her chest incision lines.</p> <p>d. OASIS Item M2000 asks if a complete drug regimen review indicated potential clinically significant medication issues, including drug interactions. The SOC documentation noted a potential drug interaction between Diltiazem and Carvedilol. However, M2000 was marked "No problems found during review."</p> <p>During an interview on 2/20/14 at 8:50 AM, the Clinical Manager stated the agency policy requires staff to report drug interactions classified as "major." She confirmed the interaction between Diltiazem and Carvedilol was classified as major per the agency's medication database.</p> <p>The SOC RN was interviewed on 2/20/14 at 8:50 AM. He stated he entered all of the patient's medications into a website to check for interactions. The website indicated a major interaction between Diltiazem and Carvedilol. The RN reviewed the record and confirmed M2000 should have been marked "Problems found during review" and the physician should have been notified of the potential interaction.</p> <p>e. OASIS Item 2010 asks if the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc) and how and when to report problems that may occur. The question was answered "Yes."</p> <p>Patient #4's POC included 2 hypoglycemic medications, Byetta and Metformin.</p>	G 322	<p>AVP call as indicated. The DOO will monitor the completion of the courses and it will become a performance issue if the course is not completed timely. The DOO or designee will also perform random home visits with follow up audit of assessment to ensure standard is met.</p> <p>Completion date: 4/1/14</p>		

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G 322	Continued From page 57 There was no documentation in the SOC visit note regarding patient education of medications.  The SOC RN was interviewed on 2/20/14 at 8:50 AM. He stated he educated the patient regarding Metformin. The RN reviewed the record and confirmed this was not documented in the SOC visit note. He stated he did not educate the patient regarding Byetta.  The SOC OASIS data did not accurately reflect Patient #4's status and services provided during the SOC visit.	G 322			
G 331	484.55(a)(1) INITIAL ASSESSMENT VISIT  A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.  This STANDARD is not met as evidenced by: Based on record review, policy review and patient and staff interview, it was determined the agency failed to ensure the initial SOC comprehensive assessment included an examination of identified items of concern for 1 of 16 patients, (#4), whose records were reviewed. This prevented staff from developing a complete POC based on patient needs. Findings include:  The agency policy titled "WC-001 WOUND CARE REFERENCE/RESOURCES/DOCUMENTATION" dated July 2013, stated, "Measure wounds at a minimum frequency of once each calendar week (usually the first visit of the week)."	G 331	G331 Agency will ensure the initial SOC assessment is comprehensive and includes the determination of patient needs and eligibility.  The DOO or designee will be responsible to correct this deficiency and ensure ongoing compliance.		

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NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER			STREET ADDRESS, CITY, STATE, ZIP CODE 9109 WEST BLACK EAGLE DRIVE BOISE, ID 83709		
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G 331	<p>Continued From page 58</p> <p>1. Patient #4 was an 81 year old woman admitted to the agency on 2/16/14 for SN services following a bilateral mastectomy for breast cancer. She was discharged from the hospital on 2/14/14. Additional diagnoses included hypertension and DM Type II. The patient's record for the certification period 2/16/14 to 4/16/14 was reviewed.</p> <p>The SOC assessment was completed by the RN on 2/16/14.</p> <p>A visit was conducted on 2/19/14 at 11:15 AM, to observe SN services at Patient #4's home. Patient #4 did not have a dressing covering the 2 incision lines on her chest. She stated a dressing was never applied to her chest after her surgery due to a severe tape allergy. However, the SOC assessment completed by the RN on 2/16/14, included documentation stating Patient #4's surgical wounds were not observable due to a non-removable dressing. There was no documentation regarding the appearance or measurements of the surgical incision lines in the SOC documentation.</p> <p>When questioned about the SOC comprehensive assessment visit on 2/16/14, the patient stated the nurse did not empty her 2 JP drains. Patient #4 stated she and her sister were able to manage the drains. The SOC assessment included documentation stating the patient had bilateral JP drains and required education in management of the drainage devices. There was no documentation noting education was provided to Patient #4 related to JP drains. There was no documentation regarding the status of the drains, or the amount and color of the drainage. There was no indication the JP drains were emptied on</p>	G 331	<p>This deficiency was reviewed with clinicians at staff meeting on 3/13/14. Clinicians will be educated on this standard at meeting week of 3/24/14. If a patient refuses to allow a clinician to observe a wound, the clinical manager must be notified immediately and the documentation must reflect the actual condition of the patient. The agency will make every effort to get the patient re-assigned to a nurse that the patient would be comfortable with in her own home as soon as possible.</p> <p>Monitoring process: 100% of SOC will be called into the clinical manager to discuss the assessment and patient needs. The DOO or clinical designee will audit 20% of active and discharge charts utilization to ensure the comprehensive assessment that accurately reflects the status of the patient. Once significant compliance is demonstrated, the DOO or designee will continue the audit of 10% of patient records. The results of these audits will be reported to the PI</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/24/2014
NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER			STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 331	Continued From page 59 the SOC visit.  During an interview on 2/20/14 at 8:50 AM, the RN confirmed Patient #4 did not have a dressing to her chest. He stated she was wearing a shirt and was reluctant to remove it so he was not able to assess the incision lines.  The RN stated he emptied the JP drains, measured the drainage and educated the patient on how to empty the JP drains. He reviewed the record and confirmed there was no documentation related to care of the JP drains or that Patient #4 was educated regarding the JP drains.  The SOC visit did not include an accurate, comprehensive assessment to determine Patient #4's needs.	G 331	committee and any problems identified will be addressed at the Quarterly PI meetings held quarterly. The findings will also be discussed on the weekly AVP call as indicated. The DOO or designee will also perform random home visits with follow up audit of assessment to ensure standard is met.  Completion date April 1, 2014		
G 337	484.55(c) DRUG REGIMEN REVIEW  The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.  This STANDARD is not met as evidenced by: Based on record review, policy review, observations during home visits, staff interview and patient interview, it was determined the agency failed to ensure the drug review was comprehensive for 5 of 16 patients (#5, #9, #13, #14, #15 ) whose records were reviewed. This had the potential to place patients at risk for adverse events or negative drug interactions.	G 337	G 337 The agency will ensure the drug regime review is comprehensive on each patient and POC includes all medications the patient is taking.  The DOO or designee will be responsible to correct this deficiency and ensure ongoing compliance.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER			STREET ADDRESS, CITY, STATE, ZIP CODE 8188 WEST BLACK EAGLE DRIVE BOISE, ID 83709	
(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)	(X6) COMPLETION DATE
G 337	<p>Continued From page 60 Findings include:</p> <p>The agency policy titled MA-002 DRUG REGIMEN REVIEW, dated April 2013, stated, "The clinician will question the patient and/or caregiver every visit regarding changes in medications including dosage changes, any new medications or any medications discontinued. (This inquiry will include over-the counter medications, herbal products, supplements and oxygen). Any discrepancies should be clarified with the patient's physician and documented in the clinical record."</p> <p>A complete review of medications did not occur in the following examples:</p> <p>1. Patient #15 was an 87 year old female, admitted to the agency on 1/06/14, for SN, PT, OT, MSW and HHA services related to methicillin resistant pneumonia, muscle weakness, atrial fibrillation and pressure ulcer stage I. Her medical record and POC for the certification period 1/06/14 through 3/06/14, were reviewed.</p> <p>LPN visit notes, dated 1/13/14, 1/14/14, 1/17/14, 1/20/14, 1/22/14, 1/24/14, 1/31/14 and 2/04/14, documented Tylenol was taken for pain. There was no documentation to indicate Tylenol had been added to Patient #15's POC medication list.</p> <p>The LPN who wrote the visit notes was interviewed on 2/20/14, beginning at 1:30 PM. She confirmed the POC did not include Tylenol.</p> <p>Patient #15's POC did not include all medications.</p> <p>2. Patient #13 was an 82 year old female,</p>	G 337	<p>Staff meetings held 3/4/14 and 3/6/14 included medication management education provided by Regional Director of Operations. Information on how to ensure the information is correct that is gathered from the patient to include sample questions for the patients. Directions on how to ensure the medication profile is updated based on the interventions from the clinicians and the office staff. All staff instructed to reconcile all active patients medications in the next 2 weeks using tool (appendix Q) distributed at meeting 3/12/14. A demonstration of patient to clinician and then clinician to clinical manager was performed at staff meeting to illustrate how to best gather all necessary information. See script (appendix R). All staff are required to complete the course #5190021 Medication management for the Home Health Clinician by 4/1/14 with associated quiz (appendix S). Clinicians educated regarding ensuring all topical medications have specific areas they</p>	

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NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER			STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709		
(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 61</p> <p>admitted to the agency on 1/12/14, with diagnoses pressure ulcer stage III, muscle weakness, hypertension, and colon cancer. Her medical record and POC for the certification period 1/12/14 through 3/12/14, were reviewed.</p> <p>An RN visit note, dated 1/15/14, documented Tylenol was taken for pain. There was no documentation to indicate Tylenol was added to Patient #13's POC medication list.</p> <p>The RN case manager was interviewed on 2/19/14 beginning at 10:30 AM. He confirmed the POC did not include Tylenol.</p> <p>Patient #13's POC did not include all medications.</p> <p>3. Patient #14 was a 52 year old female admitted to the agency on 1/29/14 for SN, PT, OT, MSW and HHA services related to traumatic fracture of her left leg, chronic skin ulcers, DM Type II, neuropathy and depressive disorder. She was hospitalized from 1/26/14 to 1/28/14. Patient #14's discharge instructions indicated she was to self administer Lovenox injections twice daily. Her medical record and POC for the certification period 1/29/14 to 3/29/14 were reviewed.</p> <p>The SOC comprehensive assessment was completed by the RN on 1/29/14 beginning at 1:30 PM .</p> <p>a. The RN's documentation stated the patient had not obtained the Lovenox from the pharmacy. The Lovenox was to be given by injection every 12 hours per the physicians' discharge orders, and therefore did not receive an evening dose of the medication 1/28/14 and morning dose 1/29/14. There was no indication the physician</p>	G 337	<p>are to be applied. Clinicians educated to notify MD regarding any medications the patients do not have in their home as well as document follow up to ensure the medications are obtained and utilized as ordered.</p> <p>Policy MA-002 Drug Regimen Review relates to the drug interactions specifically 1-6. We failed to submit this policy during the survey. (Appendix T)</p>		

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NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER			STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709		
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G 337	<p>Continued From page 62</p> <p>was notified the patient had missed 2 Lovenox doses.</p> <p>During an interview on 2/21/14 at 4:10 PM, the RN who completed the SOC assessment reviewed the record and confirmed there was no documentation stating she had informed the physician of the missing medication.</p> <p>The documentation did not indicate Patient #14's physician was notified of the patient's noncompliance with drug therapy.</p> <p>b. The medication list on Patient #14's POC included 3 topical medications:</p> <ul style="list-style-type: none"> <li>-Silver Sulfadiazine 1% topical, daily, apply to affected areas</li> <li>-Triamcinolone Acetonide 0.1% topical, 3 times daily</li> <li>-Mupirocin Calcium 2% topical, 3 times daily to affected areas</li> </ul> <p>The POC did not contain the location where the topical medications were to be applied.</p> <p>The RN was interviewed on 2/21/14 at 4:10 PM. She reviewed the record and confirmed the orders for the topical medications were incomplete.</p> <p>Patient #14's medication review was not comprehensive.</p> <p>4. Patient #5 was an 82 year old woman admitted to the agency on 2/01/14, after a hospital discharge following a procedure to repair a</p>	G 337	<p>Monitoring process: The DOO or designee will be ensuring that all active patients as of 3/1/14 have medication reconciliations completed and profiles updated by 4/1/14. The DOO will monitor the completion of the courses and it will become a performance issue if the course is not completed timely. The DOO will make random home visits to ensure this standard is met. The DOO or clinical designee will audit 20% of active and discharge charts to ensure the medication profile that accurately reflects the medications taken by the patient. Once significant compliance is demonstrated, the DOO or designee will continue the audit of 10% of patient records. The results of these audits will be reported to the PI committee and any problems identified will be addressed at the Quarterly PI meetings held quarterly. The findings will also be discussed on the weekly AVP call as indicated.</p> <p>Completion date: 4/1/14</p>		

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NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER			STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709		
(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)	(X6) COMPLETION DATE	
G 337	<p>Continued From page 63</p> <p>fractured shoulder. Additional diagnoses included pressure ulcers, insulin dependent DM and hypertension. The patient's record for the certification period 2/01/14 to 4/01/14 was reviewed.</p> <p>A visit was conducted on 2/20/14 at 11:00 AM, to observe OT services at the ALF where Patient #5 resided. Patient #5's medications were reviewed with the ALF staff and compared to the medications listed on her POC.</p> <p>The following medications were noted on the ALF medication record and were not included on Patient #4's POC:</p> <ul style="list-style-type: none"> <li>-Aspirin 81 mg tablet daily,</li> <li>-Cyanocobalamin 1000 mcg monthly.</li> </ul> <p>During an interview on 2/21/14 at 11:05 AM, the Physical Therapist who completed the SOC assessment on 2/01/14, confirmed that he failed to include 2 medications (Aspirin and Cyanocobalamin) that were on the ALF medication profile at the SOC.</p> <p>Patient #5's POC did not include all medications.</p> <p>5. Patient #9 was a 72 year old male admitted to the agency on 12/06/13, following hospital discharge related to sepsis and cellulitis of his right thigh. Additional diagnoses included osteoarthritis, insulin dependent diabetes and COPD. A referral for therapies, wound care, and diabetic management was received by the agency on 12/05/13.</p>	G 337			

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NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER	STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709
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G 337	<p>Continued From page 64</p> <p>a. A SOC and comprehensive assessment was completed by and RN on 12/06/13. The medications included on Patient #9's POC for the certification period 12/06/13 through 2/03/14 differed from the medication list on his discharge orders dated 12/05/13 as follows:</p> <ul style="list-style-type: none"> <li>- Nicotine Patch, (once daily) was included on Patient #9's discharge medication orders, however, it was not included on his POC.</li> <li>- Multivitamin tablets, (once daily) was included on Patient #9's discharge medication orders, however, it was not included on his POC.</li> <li>- Lisinopril 40 mg, 0.5 tablet, (once daily) was included on Patient #9's discharge medication orders, however, his POC indicated he was to take 1 tablet daily, which was double the dose the physician ordered.</li> </ul> <p>During an interview on 2/21/14 beginning at 1:00 PM, the RN who had completed Patient #9's comprehensive assessment reviewed his record and confirmed the medication discrepancies. He stated he was unable to explain why the POC differed from the discharge medications listed on Patient #9's discharge medication list.</p> <p>The medications on Patient #9's POC were not accurate.</p> <p>b. A comprehensive review of Patient #9's medication which included side effects, drug interactions, and duplicate drug therapy was not performed.</p> <p>The RN who performed the SOC comprehensive assessment on 12/06/13, documented a</p>	G 337		
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NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDISYS PARTNER			STREET ADDRESS, CITY, STATE, ZIP CODE 9100 WEST BLACK EAGLE DRIVE BOISE, ID 83700		
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G 337	<p>Continued From page 65</p> <p>medication review per agency policy was performed, and no problems were found. The comprehensive assessment included documentation by the RN that he had provided high risk drug education to Patient #9 and his spouse.</p> <p>Patient #9's record included an untitled document which indicated Patient #9 had a "Major" drug interaction between Trazodone and Seroquel which he was taking.</p> <p>During an interview on 2/21/14 beginning at 1:00 PM, the RN who performed the comprehensive assessment reviewed Patient #9's record and confirmed he had not reviewed the medications for drug interactions. He stated Patient #9's physician had not been informed of the reported drug interactions.</p> <p>During an interview on 2/19/14 at 3:20 PM, the Clinical Director was asked to provide a policy relating to drug interactions and identification of interactions was requested. No policy was provided as of 2/24/14 the date of the survey exit.</p> <p>A comprehensive review of all of Patient #9's medications was not performed.</p>	G 337			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  OAS001175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/24/2014
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NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDIS	STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709
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N 000	16.03.07 INITIAL COMMENTS  The following deficiencies were cited during the Medicare recertification survey of your home health agency conducted from 2/18/14 through 2/24/14.  The surveyors conducting the recertification were:  Gary Guiles, RN, HFS, Team Leader Susan Costa, RN, HFS Nancy Bax, RN, HFS Don Sylvester, BSN, RN, HFS	N 000		
N 001	03.07020.01. ADMIN.GOV.BODY  020. ADMINISTRATION - GOVERNING BODY.  N001 01. Scope. The home health agency shall be organized under a governing body, which shall assume full legal responsibility for the conduct of the agency.  This Rule is not met as evidenced by: Refer to G132 as relates to the governing body's failure to assume responsibility for the operation of the agency.	N 001	N 001  Refer to G132	
N 005	03.07020. ADMIN. GOV.BODY  N005 03. Responsibilities. The governing body shall assume responsibility for:  b. Appointing the group of professional personnel; meeting at least bi-annually.	N 005		

Bureau of Facility Standards

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

TITLE

(X6) DATE

STATE FORM

6899

MS5611

If continuation sheet 1 of 4

*[Handwritten Signature]*

*[Handwritten Title: DOO]*

*[Handwritten Date: 3/21/14]*

Bureau of Facility Standards

STATEMENT OF OFFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  OAS001176	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/24/2014
NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDIS		STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709		
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N 005	Continued From page 1  This Rule is not met as evidenced by: Based on review of agency policy and procedure, as well as staff interview, it was determined the agency's governing body failed to ensure bi-annual Professional Advisory Committee meetings occurred. The failure of the agency to conduct the twice-yearly meetings resulted in the failure to review policy and procedures, as well as review of the agency productivity and needs.  The Director of Operations confirmed on 2/24/14 at 3:40 PM, the Professional Advisory Committee had met one time in the past 12 months.  The governing body failed to conduct bi-annual meetings.	N 005	N 005  The agency will ensure bi-annual Professional Advisory Committee meeting occurs.  The DOO will be responsible to ensure this standard is met.  The agency will have a PAC meeting to present the annual program evaluation by 4/1/14. The agency will schedule another meeting in approximately 6 months' time at the meeting in March to ensure compliance to this standard.  Monitoring Process: The DOO will maintain the PAG binder in her office with the minutes from the meetings.  Completion date: 4/1/14 and ongoing.	
N 092	03.07024.01. SK.NSG.SERV.  N092 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following:  This Rule is not met as evidenced by: Refer to G143 as relates to the failure of the agency to coordinate care provided to patients.	N 092	N 092  Refer to G 143	
N 152	03.07030.01.PLAN OF CARE  N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each	N 152		

Bureau of Facility Standards

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N 152	Continued From page 2  patient by all disciplines providing services for that patient. Care follows the written plan of care and includes:  This Rule is not met as evidenced by: Refer to G158 as it relates to the failure of the agency to ensure patient care followed a written plan of care.	N 152	N 152  Refer to G 158	
N 153	03.07030.PLAN OF CARE  N153 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes:  a. All pertinent diagnoses;  This Rule is not met as evidenced by: Refer to G159 as it relates to the failure of the agency to ensure plans of care included all pertinent diagnoses.	N 153	N 153  Refer to G 159	
N 172	03.07030.06.PLAN OF CARE  N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.  This Rule is not met as evidenced by: Refer to G164 as it relates to the failure of the agency to ensure staff alert the physician changes that suggested a need to alter the plan of care.	N 172	N 172  Refer to G 164	

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NAME OF PROVIDER OR SUPPLIER  ST ALPHONSUS HHA & HOSPICE, AN AMEDIS		STREET ADDRESS, CITY, STATE, ZIP CODE 9199 WEST BLACK EAGLE DRIVE BOISE, ID 83709		
(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) COMPLETE DATE
N 174	03.07031.01 CLINICAL RECORDS  N174 01. Purpose. A clinical record containing past and current findings, in accordance with accepted professional standards, is maintained for every patient receiving home health services.  This Rule is not met as evidenced by: Refer to G236 as it relates to the failure of the agency to ensure clinical records were maintained in accordance with accepted professional standards.	N 174	N 174  Refer to G 236	
N 175	03.07031.02. CLINICAL REC.  N175 02. Contents. Clinical records must include:  a. Appropriate Identifying Information;  This Rule is not met as evidenced by: Refer to G145 as it relates to the failure of the agency to ensure a written summary reports were sent to the attending physician at least every 60 days.	N 175	N 175  Refer to G 145	