IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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PHONE 208-334-6626
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April 11, 2014

Catherine Jerrems, Administrator
First Choice Home Care, Inc.
12400 West Overland Road, Suite 100
Boise, ID 83709-0021

RE: First Choice Home Care, Provider #137108

Dear Ms. Jerrems:

This is to advise you of the findings of the Medicare/Licensure survey at First Choice Home Care, which was concluded on March 28, 2014.

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

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the Home Health Agency into compliance, and that the Home Health Agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567 and State Form 2567.

After you have completed your Plan of Correction, return the original to this office by **April 24, 2014**, and keep a copy for your records.

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

Sincerely,

SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137108	A. BUILDING _____ B. WING _____	03/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE HOME CARE	12400 WEST OVERLAND ROAD, SUITE 100 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 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your home health agency. The surveyors conducting the recertification were: Susan Costa, RN, HFS - Team Leader Nancy Bax, RN, BSN, HFS Acronyms used in this report include: ALF - Assisted Living Facility BID - Two times per day BP - Blood Pressure CHF - Congestive Heart Failure COPD - Chronic Obstructive Pulmonary Disease DM - Diabetes Mellitus DME - Durable Medical Equipment DPC - Director of Patient Care HHA - Home Health Aide HTN - Hypertension mg - milligrams MSW - Medical Social Worker OT - Occupational Therapy PICC - Peripherally Inserted Central Catheter POC - Plan of Care PTA - Physical Therapy Aide PT - Physical Therapy RN - Registered Nurse ROM - Range of Movement SN - Skilled Nursing SOC - Start of Care TED hose - Thrombo Embolic Deterrent (compression stockings) V.A.C. - Vacuum Assisted Closure	G 000	RECEIVED APR 25 2014 FACILITY STANDARDS	
G 114	484.10(e)(1(i-iii) PATIENT LIABILITY FOR PAYMENT	G 114	Please see enclosed POC	

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

Catherine Terrenoire RNC, BSN | Administrator | 4/23/14

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 114	Continued From page 1 Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to pay. This STANDARD is not met as evidenced by: Based on review of patient records, staff interview, review of policies, and patient interview, it was determined the agency failed to ensure patients were informed in writing of the extent to which payment for home health services could be expected, and the charges the individual might have to pay, for 16 of 16 patients (Patients #1-16) whose records were reviewed. This had the potential to interfere with patients'/caregivers' ability to make reasonable, informed decisions about financial matters related to the agency's care and treatment. Findings include: Policy number 2-005.3 of the agency's policy manual, revised April 2013, was titled "ADMISSION CRITERIA AND PROCESS." The policy included the statement, "If eligibility criteria is met, the patient and family/caregiver will be provided with an organization brochure and various educational materials providing sufficient information on..." The list following this statement included, "Care costs, if any, to be paid by the patient." The agency's admission packet contained a form, titled "FIRST CHOICE HOME CARE	G 114		

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G 114	Continued From page 2 STATEMENT OF ACCEPTANCE." The form included the statement, "As part of your treatment plan, we are giving you a PATIENT FOLDER that includes important information about various aspects of our services, your rights and responsibilities and financial obligations." The STATEMENT OF ACCEPTANCE further stated, "The Admitting Nurse/Therapist has explained the following forms." The list of forms included "Patient Financial Responsibility Information/Assignment of Benefits." However, the form was not included in the admission packet reviewed at the agency, the patient folders of the patients who were visited in their homes, or in patient records reviewed without home visits, as follows: 1. Patient #2 was a 91 year old female admitted to the agency on 3/20/14. A visit was made to Patient #2's home on 3/25/14 at 10:30 AM, and the patient's home folder was reviewed. There was no information related to patient financial liability in the folder. When questioned about financial coverage of home health services Patient #2 stated she did not know who was paying, but her son might know as he handled her finances. 2. Patient #7 was a 69 year old female admitted to the agency on 3/20/14. A visit was made to Patient #7's home on 3/26/14 at 3:00 PM, and the patient's home folder was reviewed. There was no information related to patient financial liability in the folder. When questioned about financial coverage of home health services Patient #2 stated she thought her insurance would pay as it had paid for home health services in the past. She stated she did not remember the nurse	G 114		

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G 114	Continued From page 3 talking about financial coverage on the initial visit. 3. Patient #8 was a 17 year old male admitted to the agency on 3/21/14. A visit was made to Patient #8's home on 3/27/14 at 11:00 AM, and the patient's home folder was reviewed. There was no information related to patient financial liability in the folder. When questioned about financial coverage of home health services, Patient #8's mother stated she did not know if their insurance would cover all of the costs. 4. Patient #13 was a 74 year old female admitted to the agency on 3/01/14. A visit was made to Patient #13's home on 3/27/14 at 12:00 PM. The patient and her son were unable to locate the home folder. When questioned about financial coverage of home health services, Patient #13 and her son stated they did not remember the physical therapist talking about payment at the time of the initial visit, but they assumed Medicare or Medicaid would pay for the services. 5. Patient #1 was a 60 year old female admitted to the agency on 1/09/14. A visit was made to Patient #1's home on 3/26/14 at 1:00 PM, and the patient's home folder was reviewed. There was no information related to patient financial liability in the folder. When questioned, Patient #1 stated she did not remember being informed about financial liability at the time of the initial visit, but assumed Medicare or Medicaid would cover the cost. 6. Patient #4 was an 87 year old male admitted to the agency on 3/21/14. A visit was made to Patient #4's home on 3/27/14 at 11:00 AM, and the patient's home folder was reviewed. There was no information related to patient financial	G 114		

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G 114	Continued From page 4 liability in the folder. When questioned, Patient #4 stated he did not remember being informed about financial liability at the time of the initial visit, but assumed Medicare would cover the cost. 7. Patient #6 was an 84 year old female admitted to the agency on 2/26/14. A visit was made to Patient #6's home on 3/26/14 at 11:00 AM, and the patient's home folder was reviewed. There was no information related to patient financial liability in the folder. When questioned, Patient #6 stated she did not remember being informed about financial liability at the time of the initial visit, but assumed Medicare would cover the cost. 8. Patient #11 was an 83 year old female admitted to the agency on 3/07/14. A visit was made to Patient #11's home on 3/25/14 at 2:30 PM, and the patient's home folder was reviewed. There was no information related to patient financial liability in the folder. When questioned, Patient #11 stated she did not remember being informed about financial liability at the time of the initial visit, but assumed Medicare would cover the cost. 9. The above referenced "Patient Financial Responsibility Information/Assignment of Benefits" form was not included in the following patient records that were reviewed without home visits: a. Patient #3 was a 90 year old female admitted to the agency on 1/07/14. b. Patient #9 was a 71 year old male admitted to the agency on 2/20/14. c. Patient #10 was a 39 year old female admitted	G 114		

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G 114	Continued From page 5 to the agency on 3/05/14. d. Patient #15 was a 73 year old male admitted to the agency on 1/27/14. e. Patient #5 was a 93 year old female admitted to the agency on 3/08/14. f. Patient #12 was a 92 year old female admitted to the agency on 2/04/14. g. Patient #14 was an 85 year old female admitted to the agency on 2/05/14. h. Patient #16 was a 43 year old female admitted to the agency on 8/09/13. 10. During an interview on 3/27/14 at 3:20 PM, the Administrator stated that when the patient was expected to have financial liability for home health services, the agency's biller put a form in the opening packet. The form showed what the patient's insurance would cover and what the patient would be responsible to pay. The clinician completing the SOC assessment was expected to explain the financial coverage to the patient. She confirmed written information regarding financial responsibility was not left in patients' homes. She further confirmed the patient records noted above did not include documentation they received information regarding financial liability prior to initiation of home health services. The agency did not inform patients in writing of the extent to which payment could be expected from federally funded programs and the charges the individuals may have to pay.	G 114		
G 145	484.14(g) COORDINATION OF PATIENT	G 145	Please see enclosed POC	

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G 145	Continued From page 6 SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure a written summary report was sent to the attending physician at least every 60 days for 2 of 2 patients (#1 and #16) 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 #1 was a 60 year old female admitted to the agency on 1/09/14 for SN and PT services related to wound care. Additional diagnoses included Type II DM, HTN, and obesity. Records were reviewed for certification periods 1/09/14 to 3/09/14 and 3/10/14 to 5/08/14. Her records did not include a 60 day summary. During an interview on 3/26/14 beginning at 11:45 AM, the Administrator reviewed Patient #1's record and confirmed that a 60 day summary was not completed or sent to her physician. She stated the agency started a new software program in January and they did not realize the summaries were not automatically generated. The agency did not ensure Patient #1's physician was provided a summary of her progress during the certification period.	G 145		

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G 145	Continued From page 7 2. Patient #16 was a 43 year old female admitted to the agency on 10/12/13 for SN services related to alpha 1 antitrypsin deficiency, an inherited disorder that can cause lung disease. Additional diagnoses included care of vascular catheter, COPD and depressive disorder. Her record for the certification period of 2/09/14 to 4/09/14 was reviewed. A recertification assessment for Patient #16's certification period from 2/09/14 to 4/09/14 was performed on 2/07/14. Her record did not include documentation a 60 day summary of her previous certification period was provided to her physician. During an interview on 3/27/14 at 4:45 PM, the Administrator reviewed Patient #16's record and confirmed that a 60 day summary was not sent to her physician. She stated the agency implemented a new software program in January and they did not realize the summaries were not automatically generated. The agency did not ensure Patient #16's physician was provided a summary of her progress during the certification period.	G 145		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review, observation, and patient and staff interview, it was determined the agency failed to ensure care followed a written POC for 6	G 158	Please see enclosed POC.	

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G 158	Continued From page 8 of 16 patients (#8, #10, #11, #12, #13 and #14,) whose records were reviewed. This resulted in medical equipment that was not provided, missed patient weight monitoring, missed blood glucose monitoring, medication and treatment administration without an order, medications not administered, missed HHA visits and additional visits that were not ordered. Findings include: 1. Patient #11 was an 83 year old female admitted to the agency on 3/07/14, following discharge from a rehabilitation facility. Additional diagnoses included irregular heartbeat, pressure ulcers on each lower extremity, dysphagia, CHF, depression, and generalized weakness. Patient #11's POC for the certification period 3/07/14 through 5/05/14 indicated she was to have HHA, SN, PT, OT and MSW services. Treatments and interventions were not provided in accordance with the POC as follows: a. The POC included a nursing intervention to educate Patient #11 to weigh herself daily and to maintain a weight log. The POC included weight parameters between 180 and 190 pounds. Patient #11's record did not include documentation of weight measurements during the SN visits on 3/13/14, 3/17/14, 3/20/14, or 3/24/14. During a home visit to observe PT services on 3/25/14 at 2:30 PM, Patient #11 stated she had a scale, but was never instructed how to use it. She indicated a digital scale that was located in the entryway by the front door. Patient #11's POC related to weight monitoring was not implements as ordered.	G 158		

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G 158	Continued From page 9 b. The POC included wound care instructions for a right ankle wound. On the admission assessment dated 3/07/14, two wounds were identified, one wound was documented as the right ankle, and the other wound was the left heel. Wound care was provided to each wound on 3/20/14, and 3/24/14, however, the POC did not include wound care instructions for the left heel wound. Wound care was provided without an order. 2. Patient #10 was a 39 year old female admitted to the agency on 3/05/14, after discharge from a rehabilitation facility following an amputation of her right leg. Additional diagnoses included insulin dependent diabetes, foot ulcers, morbid obesity, HTN, chronic kidney disease, and depression. The POC for the certification period 3/05/14 through 5/03/14, was reviewed and indicated she was to have SN, PT, OT, and MSW services. a. Patient #10's POC did not include authorization by the attending physician the agency could take orders from consulting physicians at the nephrology clinic and wound clinic. During an interview on 3/28/14 beginning at 1:50 PM, the Administrator reviewed Patient #10's record and confirmed she was receiving care from multiple physicians that were not included on the POC. Patient #10's POC was not complete to include her consulting physicians.	G 158		

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G 158	Continued From page 10 3. Patient #8 was a 17 year old male admitted to the agency on 3/21/14 following a hospitalization for meningitis. During his hospitalization, a PICC line was inserted into his right arm. He was receiving intravenous antibiotics at home through the PICC line. Patient #8's POC for the certification period 3/21/14 to 5/19/14, included a weekly SN visit to change the dressing to the PICC line insertion site. The orders did not include details of the dressing change, including the agent used to cleanse the site and the type of dressing to be applied. A visit was made to Patient #8's home on 3/27/14 at 11:00 AM, to observe a SN visit. During the visit, the RN provided care to the PICC line insertion site, including cleansing the area and appying a new dressing. During an interview on 3/27/14 at 4:15 PM, the Administrator reviewed Patient #8's record and confirmed the POC did not include specific orders for the weekly PICC line dressing change. Patient #8's POC did not include a complete order for the weekly dressing changes to his PICC line site. 4. Patient #12 was a 92 year old female admitted to the agency on 2/04/14 for SN, PT and HHA services related to pneumonia. Additional diagnoses included generalized muscle weakness, peripheral neuropathy and memory loss. a. Patient #12's POC for the certification period of 2/04/14 to 4/04/14, included orders for HHA	G 158		

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G 158	Continued From page 11 visits twice weekly for one week and one time weekly for 2 weeks. Patient #12's record did not include any documentation of HHA visits. Patient #12's record included a "Patient Communication" note, written by a Patient Care Coordinator and dated 2/18/14. The note stated, "Spoke with the HCA (Home Care Aide) today and she stated that the patient refused HCA services and this is why she has not seen the patient." The record did not include dates the patient refused HHA visits. There was no indication Patient #12's physician was notified of the patient's refusal of HHA visits. During an interview on 3/28/17 at 9:00 AM, the Administrator reviewed Patient #12's record and confirmed the physician was not notified that the HHA visits were not completed as ordered. Patient #12 did not receive HHA visits as ordered and her physician was not notified of the change in her POC. b. Patient #12's POC for the certification period of 2/04/14 to 4/04/14, included a notation stating the patient refused OT services. The patient's record included documentation of an OT evaluation visit on 2/21/14. There were no orders for OT visits. During an interview on 3/28/17 at 9:00 AM, the Administrator reviewed Patient #12's record and confirmed there were no orders for OT services. Patient #12 received OT services without a physician's order.	G 158		

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G 158	Continued From page 12 5. Patient #14 was an 85 year old female admitted to the agency on 2/05/14, for SN, PT, OT and HHA services following a hospitalization for pneumonia. Additional diagnoses included COPD and hypertension. Patient #14's POC for the certification period 2/05/14 to 4/05/14, included orders for HHA visits twice weekly. Patient #14's record included an HHA "Missed Visit" note, dated 2/06/14. The note included documentation that Patient #14 requested HHA visits begin the following week after she obtained a shower bench. The record did not contain documentation of HHA visits in the following week. During an interview on 3/27/14 at 6:20 PM, the Administrator reviewed the record and confirmed Patient #14's HHA visits were not completed as ordered. Patient #14 did not receive HHA visits as ordered on her POC. 6. Patient #13 was a 74 year old female admitted to the agency on 3/01/14, for PT, OT and HHA services after discharge from a skilled nursing facility. She spent 2 months in the skilled nursing facility due to a traumatic fracture of the lower leg. Additional diagnoses included abnormality of gait and legal blindness. Home health orders, signed by a physician at the skilled nursing facility, included orders for PT, OT, HHA and MSW services. However, the POC for the certification period 3/01/14 to 4/29/14, included orders for PT, OT and HHA. An MSW visit was provided to Patient #13 on	G 158		

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G 158	Continued From page 13 3/04/14. The MSW visit was not included on the POC. During an interview on 3/27/14 at 4:30 PM, the Administrator reviewed Patient #13's record and confirmed the MSW visit was not included on the POC. Patient #13's POC did not include an MSW visit.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on record review, patient and staff interviews, and observation, it was determined the agency failed to ensure the POC covered all services provided, equipment required, or other appropriate items in 6 of 16 patients (#1, #3, #5, #7, #11, and #13) whose records were reviewed. This had the potential to negatively impact quality and coordination of patient care. Findings include: 1. Patient #5 was a 93 year old female admitted to the agency on 3/08/14, for PT services related to abnormality of gait and lumbar sprain. Additional diagnoses included hypertension and	G 159	Please see enclosed POC	

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G 159	Continued From page 14 joint pain. Patient #5's SOC assessment was completed by a physical therapist on 3/08/14. The SOC assessment documented a BP of 190/113. The POC included direction to notify the physician for a systolic BP greater than 190 and/or a diastolic BP greater than 113. The National Institutes of Health website includes the following information regarding BP readings: A systolic blood pressure of 140 or higher, or a diastolic blood pressure of 90 or higher, is considered high blood pressure, or hypertension. During an interview on 3/27/14 at 6:00 PM, the Administrator stated the agency did not have standard vital sign parameters. She stated the parameters for each patient were determined by the clinician completing the SOC assessment and included on the patient's POC. The Administrator reviewed Patient #5's record and confirmed that the BP parameters were high and the elevated BP results should have been reported to Patient #5's physician. Patient #5's POC did not include BP parameters consistent with current standards of practice. Nor did the POC include a reason such an elevated BP parameter would be appropriate for Patient #5. 2. Patient #7 was a 69 year old female admitted to the agency on 3/20/14, for SN and OT services related to left sided paralysis and left hand contractures. Additional diagnoses included neurogenic bladder, osteoarthritis and atrial fibrillation.	G 159		

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G 159	Continued From page 15 Patient #7's POC included the following DME: Tub/shower bench, wheelchair, bedside commode, grab bars, shower wand. On 3/26/14 at 3:00 PM, a visit was made to Patient #7's home to observe an OT visit. A transfer pole was noted next to the patient's bed and a quad cane was noted in the living room. The patient stated she used both of these pieces of equipment on a daily basis. The transfer pole and quad cane were not included as DME on Patient #7's POC. During an interview on 3/27/14 at 5:25 PM, the Administrator reviewed Patient #7's record and confirmed the transfer pole and quad cane were not included in the DME listed on the POC. Patient #7's POC did not list all the equipment required by the patient. 3. Patient #13 was a 74 year old female admitted to the agency on 3/01/14, for PT, OT and HHA services after discharge from a skilled nursing facility. She spent 2 months in the skilled nursing facility due to a traumatic fracture of the lower leg. Additional diagnoses included abnormality of gait and legal blindness. Patient #13's POC for the certification period 3/01/14 to 4/29/14, included the following DME: bedside commode, walker, and noted the patient needed a shower chair. A PT visit note dated 3/20/14, documented Patient #13 was in a wheelchair when the physical therapist arrived at her home.	G 159		

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G 159	Continued From page 16 On 3/26/14 at 12:00 PM, a visit was made to Patient #13's home to observe a PT visit. During the visit, the patient stated she had the wheelchair in her home at the time home health services began. She stated she brought the wheelchair home from the skilled nursing facility . The patient stated she was using the wheelchair on a daily basis. During an interview on 3/27/14 at 4:30 PM, the Administrator reviewed Patient #13's record and confirmed the wheelchair was not included in the DME listed on the POC. Patient #13's POC did not list all the equipment required by the patient. 4. Patient #1's medical record documented a 60 year old female admitted to the agency on 1/09/14, with diagnoses of post operative wound infection, HTN, DM Type II, and morbid obesity. Her medical record for the certification period of 3/10/14 through 5/08/14 was reviewed, and indicated she was to have SN and PT services. Treatments were not provided in accordance with the POC as follows: a. An RN visit note, dated 3/17/14, documented Patient #1 attended a wound care clinic earlier that day, however, the POC did not include orders that the wound clinic was authorized to direct care related to Patient #1's wounds. The wound clinic orders included Dakins solution soaks with wound VAC changes 3 times weekly. b. Patient #1's admission assessment, as well as her recertification assessment dated 3/06/14, indicated she was receiving wound care which	G 159		

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G 159	Continued From page 17 included a wound VAC. The wound VAC, amount of suction the machine was to be set at, and specific dressings were not included on the POC. During an interview on 2/28/14, beginning at 10:20 AM, the Administrator reviewed Patient #1's record and confirmed the wound VAC, settings, and dressings were not included on her POC. The Administrator reviewed the wound clinic orders and stated she was not aware that Patient #1's physician was to include instructions on the POC that the wound clinic could write orders. Patient #1's POC was not comprehensive to include specific wound care instructions. 5. Patient #11 was an 83 year old female admitted to the agency on 3/07/14, following discharge from a rehabilitation facility. Additional diagnoses included irregular heartbeat, pressure ulcers on each lower extremity, dysphagia, CHF, depression, and generalized weakness. Her POC for the certification period 3/07/14 through 5/05/14 was reviewed. a. During a home visit on 3/25/14 at 2:30 PM, to observe PT services, the following items were noted: - Oxygen Concentrator, -"E" tanks, (portable oxygen tanks), - Large liquid oxygen storage unit, - Portable liquid oxygen delivery device, - grabber, - compression stockings, - bed side rail, - bedside commode, - first alert emergency call/response system.	G 159		

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G 159	Continued From page 18 These items were not included on Patient #11's POC. During an interview on 2/28/14 beginning at 2:00 PM, the Administrator reviewed Patient #11's record and confirmed the POC was incomplete if additional DME were used in the home that were not listed. Patient #11's POC was not inclusive of all her DME. b. At the time of the home visit on 3/25/14, Patient #11 was noted to be drinking thickened fluids. She stated she had difficulties with swallowing, and therefore thickened her liquids. The POC did not include thickened fluids. During an interview on 3/28/14 beginning at 2:00 PM, the Administrator reviewed Patient #11's record and confirmed the POC did not include information that Patient #11 required thickened fluids. Patient #11's POC was not complete to include thickened fluids. 6. Patient #3 was a 90 year old female admitted to the agency on 1/07/14, with diagnoses of pneumonia, depressive disorder, abnormal heartbeat, and CHF. Her medical record for the certification period of 1/07/14 through 3/07/14 was reviewed. Medications and treatments were not provided in accordance with the POC as follows: a. Patient #3 was discharged from the hospital on 1/06/14, following treatment for pneumonia and CHF. Her medical record included a form titled	G 159		

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G 159	Continued From page 19 "HEART FAILURE DISCHARGE ORDERS," dated 1/06/14, and signed by her physician. The orders included instructions that Patient #3 was to monitor her weight daily and to contact her physician for a weight gain of 3 pounds in one day, or 5 or more pounds over her baseline. The admission assessment, dated 1/07/14, noted Patient #3's stated weight was 94 pounds. The POC did not include an intervention to educate Patient #3 to perform daily weight monitoring or when she was to alert her physician. b. The POC included interventions for the SN to instruct Patient #3 to take nitroglycerin every 5 minutes for chest pain, and to call 911 if she had no relief after 3 doses. Patient #3's POC did not include nitroglycerin in her medication list. c. Patient #3's 1/06/14 hospital discharge orders included Ensure supplements. The POC did not include this dietary supplement. Patient #3's medical record did not include documentation of a reason the Ensure was not included on the POC. During an interview on 2/28/14, beginning at 10:00 AM, the Administrator reviewed Patient #3's record and confirmed the POC did not include nitroglycerin as a medication. She confirmed there was no documentation Patient #3 had a scale and performed daily weights. The Administrator confirmed the POC did not include Ensure dietary supplement. Patient #3's POC was not accurate to meet her medical needs.	G 159		
G 236	484.48 CLINICAL RECORDS	G 236	Please see enclosed POC	

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G 236	Continued From page 20 A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the agency failed to ensure medical records were complete, and contained accurate information for 4 of 16 patients (#1, #5, #11, and #14) whose records were reviewed. This resulted in a lack of clarity as to the patients' care from agency personnel. Findings include: 1. Patient #5 was a 93 year old female admitted to the agency on 3/08/14, for PT services related to abnormality of gait and lumbar sprain. Additional diagnoses included hypertension and joint pain. Patient #5's record for the certification period 3/08/14 to 5/06/14 was reviewed. The record contained a consent form, dated 3/01/14 (7 days prior to the SOC) and signed by someone other than the patient. There was no documentation in the record explaining who the person was who signed the consent form or why it was signed before the SOC.	G 236		

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G 236	Continued From page 21 During an interview on 3/27/14 at 6:00 PM, the Administrator stated the consent form in Patient #5's record belonged to a different patient. She stated the form had been scanned into the wrong record. The Administrator confirmed the medical record did not contain a valid consent form signed by Patient #5. Patient #5's record did not contain a valid consent form signed by her. The record did contain a consent form for a different patient. 2. Patient #14 was an 85 year old female admitted to the agency on 2/05/14 for SN, PT, OT and HHA services following a hospitalization for pneumonia. Additional diagnoses included COPD and hypertension. Patient #14's record for the certification period 2/05/14 to 4/05/14 was reviewed. The record contained an HHA Care Plan, dated 2/05/14. However, the RN's digital signature was dated 1/03/14, more than a month prior to the SOC. During an interview on 3/27/14 at 6:20 PM, the Administrator confirmed the date of the RN's signature on Patient #14's HHA Care Plan was incorrect. She stated this was caused by a scheduling error, related to the recent implementation of a new software system. Patient #14's record contained an HHA Care Plan with an incorrectly dated electronic signature. 3. Patient #1's medical record documented a 60 year old female admitted to the agency on 1/09/14, with diagnoses of post operative wound infection, HTN, DM Type II, and morbid obesity.	G 236		

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G 236	Continued From page 22 Consent forms signed by Patient #1 were dated 1/10/14, which indicated home health services were provided before proper patient consent was obtained. During an interview on 3/28/14 beginning at 10:20 AM, the Administrator reviewed Patient #1's record and stated the consents were, in fact, signed on 1/09/14 at the time of the SOC. She stated the nurse had gone out on a Sunday visit to perform the SOC, and she wrote in the wrong date. She stated it was "human error." Patient #1's record contained inaccuracies with the dates on consents as compared to the SOC date. 4. Patient #11's record documented an 83 year old female with a SOC dated 3/07/14. Her diagnoses included irregular heartbeat, CHF, diabetes, and pressure ulcers. a. Consent forms signed by Patient #11 were dated 3/10/14, however the POC and other documentation in Patient #11's record noted a SOC date of 3/07/14. b. The first page of the admission assessment noted the SOC of 3/07/14, however the visit date was noted at 3/10/14. The last page of the admission assessment included the RN's digital signature dated 1/03/2014, which was more than 2 months prior to the SOC. During an interview on 3/28/14 beginning at 10:50 AM, the Administrator confirmed Patient #11's POC indicated her SOC was 3/07/14. She stated that date was incorrect, and the SOC was entered by the scheduler before the SOC visit	G 236		

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G 236	Continued From page 23 actually occurred. The Administrator stated the agency had noted multiple errors in the electronic medical record which were related to the recent implementation of a new software system. Patient #11's medical record contained inaccurate dates.	G 236		
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 6 of 16 patients (#4, #5, #6, #7, #13, #16) whose records were reviewed. This had the potential to place patients at risk for adverse events or negative drug interactions. Findings include: Policy number 2-0075.1 of the agency's policy manual, revised April 2013, was titled "INITIAL AND COMPREHENSIVE ASSESSMENT." The policy identified the components to be included in the initial and comprehensive assessment and included the statement, "Review of medication history, as applicable to care and service and current medication use, including prescription, over the counter medications and herbal medications, and identifying drug interactions,	G 337	See enclosed POC	

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G 337	Continued From page 24 duplicative drug therapy, and noncompliance with therapy." 1. Patient #5 was a 93 year old female admitted to the agency on 3/08/14, for PT services related to abnormality of gait and lumbar sprain. Additional diagnoses included hypertension and joint pain. Patient #5's record for the certification period 3/08/14 to 5/06/14 was reviewed. The SOC assessment was completed by a physical therapist on 3/08/14. The medication profile included a medication listed as "Pain Relief, one BID." There was no documentation to indicate the actual medication or the dosage. The profile listed 2 additional analgesics (pain relief medications.) The record indicated the medications had been reviewed by an RN. Given the name of the medication and its dosage were lacking, it was unclear how the medication was evaluated for duplicative therapy or drug interactions. During an interview on 3/27/14 at 6:00 PM, the Administrator stated the Quality Improvement Nurse reviews all medication profiles completed by therapists. She was not able to explain how Patient #5's medication profile was reviewed for duplicative therapy or drug interactions without containing the medication or dosage. Patient #5's medication profile did not contain the necessary information to complete a review for duplicative therapy or drug interactions. 2. Patient #7 was a 69 year old female admitted to the agency on 3/20/14 for SN and OT services	G 337		

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G 337	Continued From page 25	G 337		

related to left sided paralysis and left hand contractures. Additional diagnoses included neurogenic bladder, osteoarthritis and atrial fibrillation. Patient #7 resided in an ALF. Patient #7's record for the certification period 3/20/14 to 5/18/14 was reviewed.

Patient #7 received 2 SN visits and was discharged from nursing on 3/25/14. An order was received on 3/21/14 for a PT evaluation. Patient #7 was evaluated by a physical therapist on 3/25/14.

A home visit was made on 3/26/14 at 3:00 PM, to observe a visit by a Certified Occupational Therapy Assistant. Following the visit, a list of Patient #7's current medications was obtained from the ALF nurse. The list of current medications was compared to the medication profile in Patient #7's record.

The ALF current medication list included Fenofibrate, a medication used to lower cholesterol. The start date for this medication was noted as 10/18/12 on the ALF medication list. Fenofibrate was not included on Patient #7's home health medication profile.

The ALF current medication list for Patient #7 included Coumadin, a medication used to thin the blood. On 3/25/14, the Coumadin dosage was changed. It had been 5 mg every Monday, Wednesday, Friday and Sunday. It was changed to 2.5 mg on Tuesday, Wednesday, Thursday, Saturday and Sunday, and 5 mg on Monday and Friday. Patient #7's home health medication profile was not updated with the new Coumadin dosage. During the home visit on 3/26/14, the therapist did not ask Patient #7 if she had any

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G 337	Continued From page 26 changes to her medications. During an interview on 3/27/14 at 5:25 PM, the Administrator reviewed the record and confirmed Fenofibrate was not included on Patient #7's home health medication profile. She also confirmed the Coumadin dosage was not updated. The Administrator indicated she would not expect therapists to make changes to the current medication profile. Patient #7's record did not include a current and comprehensive list of medications. 3. Patient #13 was a 74 year old female admitted to the agency on 3/01/14 for PT, OT and HHA services related to a traumatic fracture of the lower leg. Additional diagnoses included abnormality of gait, legal blindness and constipation. Patient #13's POC and medication profile included Norco 5-325 mg to be taken every 4 hours as needed for pain, and Docusate Sodium (a stool softener) 100 mg, to be taken daily for constipation. Constipation is a common problem for patients taking pain medications. The start date for both medications was documented as 1/01/14. A home visit was made on 3/26/14 at 12:00 PM, to observe a PT visit. Patient #13's medications were reviewed during the home visit. There was no Docusate Sodium in patient #13's home and she stated she had never taken the medication. Patient #13 stated her son went to the pharmacy to pick up her medications and he was told by the pharmacist that Docusate Sodium was an over the counter medication, not a prescription. Her	G 337		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137108	A. BUILDING _____ B. WING _____	03/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE HOME CARE	12400 WEST OVERLAND ROAD, SUITE 100 BOISE, ID 83709

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G 337	Continued From page 27 son did not purchase the Docusate Sodium and purchased mineral oil instead. Mineral oil was not included on Patient #13's current medication profile. There was no documentation in the medical record to indicate the patient did not have Docusate Sodium until an MSW visit note on 3/24/14 (23 days after the SOC on 3/01/14), documented the patient's son did not get it from the pharmacy. A PT note on 3/06/14, documented that Patient #13 refused to take Norco (pain medication) due to constipation. There was no indication the patient was educated regarding the use of stool softeners. During the home visit on 3/26/14 at 12:30 PM, the physical therapist stated Docusate Sodium was not in the home when she did the SOC assessment, but Patient #13's son was going to the pharmacy to pick up her medications later that day. She confirmed she had not followed up after the SOC visit to ensure Patient #13 had obtained all medications ordered. She also confirmed she was not aware Patient #13 had obtained mineral oil. During an interview on 3/27/14 at 4:30 PM, the Administrator reviewed Patient #13's record and confirmed the POC and medication sheet were inaccurate. She stated the physical therapist should have followed up to ensure all medications ordered were obtained and taken as directed by the physician. Patient #13's POC and medication profile did not accurately list the medications Patient #13 was currently using.	G 337		

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G 337	Continued From page 28 4. Patient #16 was a 43 year old female admitted to the agency on 10/12/13 for SN services related to Alpha 1 antitrypsin deficiency, an inherited disorder that can cause lung disease. Additional diagnoses included care of vascular catheter, COPD and depressive disorder. Her record for the certification period of 2/09/14 to 4/09/14 was reviewed. The SN visit note, dated 2/21/14, included documentation stating Patient #16 put on her oxygen at 3 liters per minute. Patient #16's POC for the certification period 2/09/14 to 4/09/14, included oxygen. However, documentation related to the amount and manner in which oxygen was supplied to Patient #16 was not included on the POC. During an interview on 3/27/14 at 4:45 PM, the Administrator reviewed Patient #16's record and confirmed the oxygen was not listed as a medication with amount and manner of administration. Patient #16's POC did not include oxygen with amount and manner of administration. 5. Patient #4 was a 90 year old male admitted to the agency on 3/21/14, following discharge from a rehabilitation facility after an anterior cervical fusion (a surgical procedure in which the surgeon goes through the front of the neck to repair the vertebrae. Diagnoses included generalized muscle weakness, spinal stenosis, COPD, gout, HTN, and chronic kidney disease. Patient #4's records and POC for the certification period 3/21/14 through 5/20/14 were reviewed.	G 337		

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G 337	Continued From page 29 A home visit was conducted on 3/27/14 at 11:00 AM, to observe services provided by the PTA. After the therapy was completed, Patient #4 and his family were interviewed. Patient #4 did not speak English, and a family member was able to translate. The following medication discrepanciess were noted on Patient #4's POC: a. The POC included Tramadol, however Patient #4's family member stated he did not have the medication, and had not taken it since being discharged from the hospital. b. The POC included aspirin 325 mg 1 tablet daily. Patient #4's family member confirmed he was taking the aspirin each morning. However the container of aspirin, when provided to the surveyor to examine, had expired in July 2011. The expiration date was confirmed with the PTA. c. A form titled "Discharge Medication Reconciliation," dated 3/19/14, and signed by a physician, included Plavix, 50 mg twice a day, (a medication to prevent blood clots). The POC did not include the medication, and Patient #4's family member stated he was not taking Plavix. The family member brought forth a bag of medications, and stated it contained all of Patient #4's medications, Plavix was not in the bag. d. Patient #4's family member stated he took Ibuprofen, 200 mg occasionally for pain. The Ibuprofen was not included on the POC. During an interview on 3/28/14 beginning at 1:40 PM, the Administrator reviewed Patient #4's record and confirmed Plavix and Ibuprofen was not included on his POC.	G 337		

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G 337	Continued From page 30 Patient #4's medications were not reconciled with the POC and hospital discharge list. 6. Patient #6 was an 84 year old female admitted to the agency on 2/26/14 for SN, PT, OT, and MSW services related to dementia, depression, HTN, and generalized weakness. Patient #6's records and POC for the period 2/26/14 through 4/26/14 were reviewed. A home visit was conducted on 3/26/14 at 11:00 AM, to observe care provided by the RN. During the nursing visit Patient #6 reported to the RN that she was taking psyllium, (a fiber product), as well as Fish oil, on a daily basis, and took Excedrin as needed for pain. The medications and supplements were not included on the POC. During an interview on 3/28/14 beginning at 1:30 PM, the Administrator reviewed Patient #6's record and confirmed the Fish oil, psyllium, and Excedrin were not on her POC. Patient #6's POC did not include all the medications and supplements she was taking.	G 337		

Bureau of Facility Standards

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	OAS001172	A. BUILDING: _____ B. WING _____	03/28/2014

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FIRST CHOICE HOME CARE	12400 WEST OVERLAND ROAD, SUITE 100 BOISE, ID 83709

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the licensure survey of your home health agency completed 3/24/14 through 3/28/14. The surveyors conducting the survey were: Susan Costa RN, HFS, Team Lead Nancy Bax, RN, BSN, HFS	N 000		
N 155	03.07030. PLAN OF CARE N155 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: c. Types of services and equipment required; This Rule is not met as evidenced by: Refer to G158	N 155	Please see enclosed POC RECEIVED APR 25 2014 FACILITY STANDARDS	
N 160	03.07030.PLAN OF CARE N160 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: h. Nutritional requirements; This Rule is not met as evidenced by:	N 160		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Catherine E Jeremy	Administrator	4/23/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 160	Continued From page 1 Refer to G158	N 160		
N 161	03.07030.PLAN OF CARE N161 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: i. Medication and treatment orders; This Rule is not met as evidenced by: Refer to G337	N 161		
N 169	03.07030.03.PLAN OF CARE N169 03. Orders for Therapy Services. Orders for therapy services include the specific procedures and modalities to be used and the amount, frequency, and duration. This Rule is not met as evidenced by: Refer to G158	N 169		
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check	N 173		

Bureau of Facility Standards

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N 173	Continued From page 2 all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G337	N 173		
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	N 174		
N 186	03.07031.03.CLINICAL REC. N186 03. Clinical and Progress Notes, and Summaries of Care. Clinical and progress notes must be written or dictated on the day service is rendered and incorporated into the clinical record within seven (7) days. Summaries of care reports must be submitted to the attending physician at least every sixty (60) days. This Rule is not met as evidenced by: Refer to G145	N 186		

G 114

- Educational action to introduce new form for initiating " Patient Liability For Payment" – see attached form and Power Point presentation slides
- May 6, 2014, new form introduced to staff (21/22 staff present at training)
- Implementation – immediately, scheduler to add form to SOC packets, staff to review with patient, and patient acknowledges review when signing "First Choice Home Care Statement of Acceptance" (see highlighted "copay information if applicable –patient received written information". The letter stays with patient in their SOC packet, the statement of Acceptance is signed by patient and returned to the office for scanning.
- May 6, 2014 correction date for education and implementation
- QI coordinator will monitor all SOC for compliance on all patients with co payments
- Cathy Jerrems, RN, BSN, First Choice Home Health Administrator is responsible for implementing the acceptable Plan of Correction

G 158

- Care follows a written Plan of Care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine (See slides 1-7 for this G tag)
- Addition of following forms presented to staff to added to all CHF patient SOC packets
  Heart Care Zones
  My Weight and Symptom Tracker
  Fazzi OASIS Walk – handout to all staff and reviewed
- Completion date for education of this G tag – May 6, 2014 with implementation immediate and QI Coordinator to monitor and track compliance quarterly with reports to administrator (QI Coordinator to develop form by May 27, 2017 to include check for BG monitoring, Weights, Medication profile/treatments, Frequency and Duration, HHA visits
- Education included instruction for area on OASIS to add all physician names that could potentially write orders for the patient
- See also attached PICC Line Policy, Fazzi OASIS Walk,
- Clinical Director to implement this Plan of Correction
- Also attached – Intake checklist

Tag 236

- Clinical Record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. (see Power Point slides for this tag)

G145

- Template created on Kinnser software as "60 day Recertification Summary"
- Staff educated on 5/6/14 regarding how to access and complete summary. Example given to clinicians.
- A 60 day summary did not exist inside Kinnser software leading to the deficiency. A template had to be created by the agency. The clinicians will be able to complete the 60 day Summary when they complete Recertification documentation.
- 60 day summaries will be sent to physician by the order manager upon completion by clinician and approval by QI.
- QI will ensure that 60 day Summaries are completed when clinician completes Recertification documentation on every recert. This process will be ongoing.

G159

- Clinicians were provided with education (performed by Clinical Director of Nursing and Therapy Director) on 5/6/14 regarding specific expectations to correct citations on this G tag. Topics included education on vital sign parameter setting for all patients, notification of MD for any vitals outside of parameters, ensure that all applicable DME is listed on SOC documentation/485, include "May take orders from..." for any other MDs that may give orders to clinicians, include specific details for wound supplies, parameters for wound vac, ultrasound and electrical stimulation on all plans of care, address all hospital discharge orders, and also include dietary supplements (ie. Ensure, thickener) to plan of care.
- QI will review 100% of Start of Care documentation on ongoing basis.
- QI performs complete review of 100% of all 485's to include that it meets documentation standards.
- QI along with additional agency staff will perform audit of 25% of charts during 2nd and 3rd quarter of 2014 as part of Remediation plan.
- QI along with additional agency staff will perform ongoing audits on 10% of all charts by using audit tool. This will be an ongoing process.

- Intake has revised "Intake Checklist" to assist with accuracy of dates for SOC, referral, discharge dates
- Qi Coordinator will review each OASIS for accuracy of dates by checking referral intake check list and date of SOC – this will be ongoing
- Clinical will implement this G tag POC (see attached intake check list)

Tag 337

- The comprehensive assessment must include review of all medications the patient is currently using . . . . . .
- This POC will be reviewed in the May 6, 2014 Survey Education Staff meeting
- Medication Profile – See attached form
- Staff educated on "Medication Reconciliation/Snapshot" and follow up of 1. High Risk, 2. Moderate Risk 3. Low risk medications
- All High Risk profiles will be faxed to the physician for update/changes/further instruction
- QIC monitors every OASIS/Medication Profile for compliance with Medication Reconcilliation and physician notification of high risk profile (Coumadin changes to be entered into Medication Profile by Intake Staff)
- Clinical Director to implement this POC beginning May 6, 2014