

COPY



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 70073020000140388492

April 25, 2013

Becky Staker, Administrator
Rexburg Home Health
Po Box 3881
Idaho Falls, ID 83403

RE: Rexburg Home Health, Provider #137090

Dear Ms. Staker:

Based on the survey completed at Rexburg Home Health, on April 4, 2013, by our staff, we have determined Rexburg Home Health is out of compliance with the Medicare Home Health Agency (HHA) **Conditions of Participation of Acceptance of Patients 42 CFR 484.18, POC and, Medical Supervision, Skilled Nursing Services 42 CFR 484.30, and Clinical Records 42 CFR 484.48.** To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

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

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

An acceptable Plan of Correction contains the following elements:

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

Becky Staker, Administrator
April 25, 2013
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 May 19, 2013. 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 May 10, 2013.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **May 8, 2013.**

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,


SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care


SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

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



Rexburg Home Health and Hospice

280 East Main Street
Rexburg, Idaho 83440

Via Federal Express Tracking No: 9268 9488 0683

May 7, 2013

Sylvia Creswell, Co-Supervisor
Non-Long Term Care
Idaho Department of Health and Welfare
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83705

Re: Plan of Correction – Rexburg Home Health
Medicare Provider No.13-7090

Dear Sylvia:

Enclosed you will find our Credible Allegations in response to the survey conducted April 4th, 2013.

Please extend our thanks to Susan Costa who was helpful and professional throughout the survey..

If there is any other information I can provide just let me know.

Best Regards:

Robert Collette

/s
enclosure (1)

RECEIVED

MAY 08 2013

FACILITY STANDARDS

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

PRINTED: 04/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/04/2013
NAME OF PROVIDER OR SUPPLIER REXBURG HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 280 EAST MAIN STREET REXBURG, ID 83440	
(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey of your home health agency. The surveyor conducting the recertification was:</p> <p>Susan Costa, RN, HFS, Team Leader</p> <p>Acronyms used in this report include:</p> <p>BP = Blood Pressure CHF = Congestive Heart Failure CKD = Chronic Kidney Disease COPD = Chronic Obstructive Pulmonary Disease DM = Diabetes Mellitus DME = Durable Medical Equipment HHA = Home Health Aide HTN = Hypertension IM = Intramuscular mcg = microgram mEq = mellequivalent mg = milligram OT = Occupational Therapy POT = Plan of Treatment PRN = as needed pt = patient PT = Physical Therapy PTA = Physical Therapy Assistant RN = Registered Nurse ROC = Resumption of Care SN = Skilled Nursing SOC = Start of Care</p>	G 000	<p>Please refer to the attached Appendix I for all plans of correction.</p> <p style="text-align: center;">RECEIVED MAY 08 2013 FACILITY STANDARDS</p>	
G 144	<p>484.14(g) COORDINATION OF PATIENT SERVICES</p> <p>The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.</p>	G 144		

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

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 144	Continued From page 1 This STANDARD is not met as evidenced by: Based on staff interview, review of medical records and agency policies, it was determined the agency failed to ensure care coordination between disciplines was documented for 3 of 6 patients (#2, #4, and #5) who received services from more than one discipline and whose records were reviewed. This had the potential to interfere with quality and continuity of patient care. Findings include: A policy titled "MULTI DISCIPLINARY COMMUNICATION," reviewed January 2013, included: "all personnel who are contributing to the patients' care will coordinate said care through case conferences, communication notes, plans of care and the medical record to ensure that all patients receive the highest quality of care." Coordination of patient care was not noted as follows: 1. Patient #2 was an 86 year old female admitted to the agency on 3/07/13 for nursing and therapy services related to muscle weakness, chronic kidney disease, and congestive heart failure. The POT for the certification period 3/07/13 to 5/05/13 included orders for SN 2 times a week for 1 week and 1 time a week for 2 weeks. PT was ordered 1 time a week for 1 week, and 2 times a week for 7 weeks. OT was ordered 2 times a week for 4 weeks. Visit notes for Patient #2 from 3/07/13 to 4/02/13 were reviewed for documentation of coordination of care between the disciplines. There were a	G 144	Please refer to the attached Appendix I for all plans of correction.		

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G 144	<p>Continued From page 2 total of 5 nursing visits and 16 therapy visits.</p> <p>a. The POT included under Section 22, (Goals/Rehabilitation Potential/Discharge Plans), "Abnormal O2 (oxygen) saturations will be reported to physician." The record indicated Patient #2 had multiple episodes of low oxygen saturations. Oxygen saturation levels as defined in "Procedure Manual for Critical Care, Fourth Edition," indicate the percentage of hemoglobin saturated with oxygen. A normal value would be 97% to 99% in a healthy individual. Values under 90% would be considered low. There was no documentation of communication between the Case Manager and the therapy disciplines of monitoring for evidence of respiratory distress or her need for supplemental oxygen as follows:</p> <p>-3/07/13 at 2:58 PM, the RN documented in her admission note Patient #2's oxygen saturation was 70%. The RN noted after Patient #2 rested for 30 minutes, her oxygen saturation improved to 86%. The RN wrote she would monitor for 1 week and contact the physician for orders as indicated. The record did not contain documentation the physician was notified.</p> <p>-3/18/13 at 3:08 PM, the PTA documented Patient #2's oxygen saturation was 86%. The RN had been in to visit Patient #2 earlier that day and did not record an oxygen saturation level. The record did not indicate the PTA notified the RN Case Manager of the low oxygen level.</p> <p>During an interview on 4/03/13 at 12:30 PM, the RN Case Manager reviewed Patient #2's record and confirmed the documentation of low oxygen saturations. She stated she possibly monitored</p>	G 144	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 144	<p>Continued From page 3</p> <p>Patient #2's oxygen on 3/18/13 during her visit, but forgot to record it. The RN Case Manager stated the PTA did not notify her regarding the low saturation of 86%.</p> <p>Coordination of care among personnel furnishing care to Patient #2 was not documented.</p> <p>2. Patient #5 was a 91 year old female admitted to the agency on 1/21/12 for nursing and therapy services related to muscle weakness, dementia, and gait abnormality. The POT for the certification period 1/21/12 to 3/20/12 included orders for SN once a week for 3 weeks, PT 3 times over the first 10 days, then twice a week for 2 weeks. HHA services were ordered twice weekly for 8 weeks.</p> <p>Visit notes for Patient #5 from 1/21/12 to 2/27/12 were reviewed for documentation of coordination of care between the disciplines. There was a total of 2 nursing visits and 9 therapy visits, and no documentation of interdisciplinary care coordination. The nursing visit note dated 1/26/12, included "...will do prn visits from here on out." There were no further nursing visits to Patient #5. The nursing note did not contain documentation of communication with the physical therapist that stated the physical therapist would be the only skilled discipline following Patient #5. The delegation of HHA supervisory duties was not clear. Patient #5 received Home Health services for 5 weeks with a single HHA supervisory visit, dated 2/08/12.</p> <p>In an interview on 4/03/13 at 11:50 AM, the Administrator reviewed Patient #5's medical record and confirmed there was no</p>	G 144	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 144	<p>Continued From page 4</p> <p>documentation by the RN case manager of transitioning patient care to the PT. She confirmed an additional HHA supervisory visit by the RN case manager should have occurred. The Administrator stated HHA supervisory visits were performed by the RN case manager, and not delegated to the PT.</p> <p>Coordination of care among personnel furnishing care to Patient #5 was not documented.</p> <p>3. Patient #4 was a 77 year old male admitted to the agency on 9/27/12 for nursing and therapy services related to generalized muscle weakness and type II diabetes. The POT for the certification period 9/27/12 to 11/25/12 included orders for skilled nursing one time the first week, 2 times a week for 4 weeks, and PT 3 times a week for 4 weeks.</p> <p>Visit notes for Patient #4 from 9/27/12 to 10/16/12 were reviewed for documentation of coordination of care between the disciplines. There was a total of 6 RN visits and 4 PT visits, and no documentation of interdisciplinary care coordination. The PT visit note dated 10/15/12 documented Patient #4 would be moving to another state for the winter, and would be discharged from therapy services at that time. There was no documentation of communication with the physician or of the RN Case Manager. A "SN OASIS-C Discharge" note, dated 10/16/12, documented "SN into see pt for home health visit and to discharge pt from services." The record did not contain evidence of communication with the physical therapist or Patient #4's physician for discharge orders.</p>	G 144	<p>Please refer to the attached Appendix I for all plans of correction.</p>		

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G 144	Continued From page 5 In an interview on 4/02/13 at 1:35 PM, the Administrator reviewed Patient #4's medical record and confirmed there was no documentation of coordination of care. Coordination of care among personnel furnishing care to Patient #4 was not documented.	G 144	Please refer to the attached Appendix I for all plans of correction.		
G 156	Coordination of care was not documented. 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on observation, patient interview, medical record review and staff interview, it was determined the agency failed to ensure care was provided in accordance with patients' POCs, that the POCs included all pertinent diagnoses, and the physician was notified if the POCs were altered or patients' conditions changed. Failure to provide care in accordance with a thorough POC had the potential to interfere with progress toward discharge from the agency. Findings include: 1. Refer to G158 as it relates to the failure of the agency to notify physicians when the POT for patients was altered by missed visits or not otherwise followed. 2. Refer to G159 as it relates to the failure of the agency to ensure all pertinent diagnoses were addressed in patients' POTs. 3. Refer to G160 as it relates to the failure of the agency to consult the physician to approve the	G 156			

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G 156	Continued From page 6 POT. 4. Refer to G164 as it relates to the failure of the agency to notify the physician with changes in patients' conditions. 5. Refer to G165 as it relates to the failure of the agency to ensure drugs and treatments were administered by staff only upon a physician's order. The cumulative effect of these negative systemic practices impeded the agency in providing quality care in accordance with established POTs.	G 156	Please refer to the attached Appendix I for all plans of correction.	
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review, and patient, and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 4 of 6 patients (#1, #2, #4, and #5) whose records were reviewed. This resulted in unauthorized treatments as well as omissions of care and had the potential to result in unmet patient needs. Findings include: 1. Patient care was not provided as ordered on the physician ordered POT as follows: a. Patient #1 was a 72 year old female whose SOC was 9/22/10. Her diagnoses included MS (Multiple Sclerosis) and neurogenic bladder (a	G 158		

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G 158	<p>Continued From page 7</p> <p>dysfunction of the urinary bladder due to disease of the central nervous system). The POT for the certification period 1/09/13 to 3/09/13 included orders for SN services for catheter change and assessment.</p> <p>Patient #1 was seen by a physician on 2/12/13 and a blood clot was identified in her left leg. Her record contained a verbal order from a physician (a different physician from the one included on the POT), for Lovenox 80 mg to be administered sub-cutaneously twice daily until her INR was >2. INR (international normalized ratio) is a test to determine the clotting tendency of blood, with a target range of 2-3.</p> <p>On a "Visit Note Report," dated 2/13/13 at 7:51 PM the RN documented she taught the family to administer Lovenox injection for a new onset diagnosis of DVT (deep vein thrombus, or "blood clot") in Patient #1's left leg. The RN documented the family had taken measurements of the calf, foot and thigh, however, the RN had not measured or documented measurements of Patient #1's foot, thigh and calf, although she noted "profound unilateral swelling." The RN noted she would obtain another INR on Friday 2/15/13.</p> <p>There was no communication with the attending physician to inform of the blood clot, orders for the Lovenox injections, teaching the family to administer the injections, or of the INR testing. There was no indication on the POT that the attending physician was aware of an additional medical provider for Patient #1.</p> <p>There was no SN visit on Friday (2/15/13) as</p>	G 158	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 158	<p>Continued From page 8 planned the previous visit.</p> <p>On 2/18/13, the SN visit note indicated she obtained an INR result of 2.7, the result was called to a physician, and the Lovenox was discontinued. The RN did not indicate which physician was notified of the INR. The RN did not document the appearance of Patient #1's left leg with the blood clot. The RN also documented she had administered a bladder irrigation. There were no orders on the POT for bladder irrigation.</p> <p>On 2/25/13 at 8:08 AM, a SN visit note documented a wound on Patient #1's left knee, to which she provided wound care. There was no documentation of the appearance of Patient #1's left leg or measurements of the area with the blood clot. In addition, the RN documented she provided bowel care that included disimpaction of stool, and administered a urinary bladder irrigation. There were no orders on the POT for disimpaction, bladder irrigation, or wound care.</p> <p>On 2/27/13 at 8:11 AM, a SN visit note documented 4+ edema on Patient #1's lower left leg. There was no documentation of the appearance of her left knee wound that was identified the previous visit. She noted bowel care including disimpaction was performed. There were no orders on the POT for disimpaction.</p> <p>On 3/01/13 at 8:04 AM, a SN visit note documented Patient #1 had a wound on her right knee with serous exudate, and moderate amount of granulation tissue. The visit note on 2/25/13 had identified a wound on the left knee, bowel care that included disimpaction of stool, and</p>	G 158	Please refer to the attached Appendix I for all plans of correction.	

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G 158	<p>Continued From page 9</p> <p>administration of a urinary bladder irrigation of 30 ml Gentamycin. There were no orders on the POT for disempaction, bladder irrigation, or wound care. Gentamycin bladder irrigation was not included on the medications listed on the POT.</p> <p>On 3/05/13 at 8:07 AM, a SN visit/recertification assessment documented a wound on Patient #1's left knee. In addition, her left leg was noted to have 4+ edema. The RN documented she provided wound care to Patient #1's left knee pressure ulcer wound. Bladder irrigation was administered, with documentation of Vancomycin 30 ml. Vancomycin bladder irrigation and wound care was not included on the POT.</p> <p>There was no documentation the RN had communicated with Patient #1's physician to obtain orders for an additional certification period. There was no documentation of a summary of care and progress during the certification period sent to the physician.</p> <p>The POT for the certification period 3/10/12 to 5/08/13 included orders for SN visits effective 3/24/13, 3 visits a week for 3 weeks, and then 4 visits over the next 4 weeks for a total of 4 PRN visits. The POT included orders for the skilled nurse to assess/evaluate co-morbid conditions including Foley catheter change every month and as needed. The POT did not include wound care to the left/right knee or evaluation of the left leg blood clot and edema. The POT did not include bladder irrigation or the irrigation solution to be used.</p> <p>On 3/25/13 at 8:02 AM, a SN visit note</p>	G 158	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 158	<p>Continued From page 10</p> <p>documented 4+ edema in Patient #1's left leg, but no measurements were recorded. There was no documentation of a wound. The RN noted she provided bowel care that included disempaction of stool. There were no orders on the POT for disempaction.</p> <p>On 3/27/13 at 8:08 AM, a SN visit note documented 3+ edema in Patient #1's left leg, but no measurements were recorded. The RN noted she provided bowel care that included disempaction of stool. There were no orders on the POT for disempaction.</p> <p>On 3/29/13 at 8:20 AM, a SN visit note documented 3+ edema in Patient #1's left leg, and she wrapped Patient #1's lower left leg with coban for edema. The RN noted she provided bowel care that included disempaction of stool. In addition, the RN noted she obtained an INR result of 1.4, and instructed Patient #1's family to report the results to the physician. There were no orders on the POT for disempaction, wrapping of the leg, or to obtain an INR sample. The RN did not communicate the results of the INR to the physician.</p> <p>On 4/01/13 at 8:21 AM, a SN visit note documented 4+ edema in Patient #1's left leg, but no measurements were recorded. The RN noted she provided bowel care that included disempaction of stool. There were no orders on the POT for disempaction.</p> <p>A home visit was conducted on 4/03/13 from 8:00 to 9:30 AM to observe SN services provided and to speak with the patient and family. The RN replaced Patient #1's urinary catheter, then</p>	G 158	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 158	<p>Continued From page 11</p> <p>administered an irrigation solution which she stated was Vancomycin. The RN provided bowel care that included disimpaction of stool. There were no orders on the POT for disimpaction or urinary bladder irrigation.</p> <p>Upon review, the irrigation solution label read "Gentamycin 400mg/ml in 1000cc Normal Saline, instill into bladder 2 times daily."</p> <p>The RN Case Manager was interviewed on 4/03/13 beginning at 2:10 PM. She reviewed Patient #1's record and confirmed she had provided bowel care, wound care and blood testing that had not been ordered on the POT. She stated the documentation of the wound on the right leg had been an error, she had meant the left leg. The RN stated she was on vacation at the time Patient #1 developed a blood clot in her left leg. She stated the RN who saw Patient #1 on 2/15/13 and 2/16/13, and instructed the family in Lovenox administration was no longer employed at the agency, and was not available for interview.</p> <p>Wound care, bladder irrigation, blood testing, and bowel care was not included on Patient #1's POT.</p> <p>b. Patient #2 was an 86 year old female with CKD, muscle weakness, and CHF who was admitted to the agency on 3/07/13. The POT for the certification period 3/07/13 to 5/05/13 included orders for SN, PT, OT, and HHA services.</p> <p>The POC included goals of "RESPIRATORY EXACERBATIONS WILL BE IDENTIFIED PROMPTLY AND INTERVENTIONS INITIATED</p>	G 158	Please refer to the attached Appendix I for all plans of correction.	

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G 158	<p>Continued From page 12</p> <p>TO MINIMIZE ASSOCIATED RISK." The POC also included vital sign parameters for heart rate, blood pressure, respiratory rate and temperature, but did not include parameters for oxygen saturations. Oxygen saturation levels as defined in "Procedure Manual for Critical Care, Fourth Edition," indicate the percentage of hemoglobin saturated with oxygen. A normal value would be 97% to 99% in a healthy individual. Values under 90% would be considered low.</p> <p>The admission assessment, dated 3/07/13 at 2:58 PM, documented Patient #2's oxygen saturation as 85%. The assessment documented Patient #2 was homebound due to shortness of breath, and had been recently hospitalized for CHF. The admission assessment indicated Patient #2 was on supplemental oxygen, but did not include the rate or method of oxygen delivery. A narrative note by the admitting nurse stated "Patient's oxygen levels low, 70 percent by pulse ox, (sic) after 30 minutes of rest oxygen saturation per oximeter raised 86 percent. Will monitor for 1 week contact physician for orders, as indicated."</p> <p>The nursing note did not indicate Patient #2's physician was notified for the low oxygen saturation readings.</p> <p>A nursing visit note, dated 3/11/13 at 2:25 PM, indicated Patient #2's oxygen saturation level was 90%. The note stated Patient #2 continued to have shortness of breath, and had used oxygen at night. The nursing note did not indicate if Patient #2 was on oxygen at the time the saturation was obtained, or if the physician had been notified. A narrative note by the nurse</p>	G 158	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 158	<p>Continued From page 13 stated "...Faxed prescription for Arenesp to Caremark."</p> <p>The medical record did not contain evidence of physician notification regarding the low oxygen saturation or of orders for Arenesp.</p> <p>A nursing visit note, dated 3/15/13 at 1:52 PM, stated "Gave patient injection of Aranesp per doctor's orders. Discussed benefits of Aranesp injection as well as schedule B-12 injections for next week." The note did not indicate the site or dose of the injection.</p> <p>The medical record did not contain evidence of physician orders for administration of Aranesp.</p> <p>A nursing visit note, dated 3/18/13 at 12:21 PM, did not contain an oxygen saturation reading. The narrative note included: "Gave pt B-12 injection, R [right] hip, pt tolerated well." The note did not indicate the dose of the injection.</p> <p>The medical record did not contain evidence of physician orders for administration of B-12 injections.</p> <p>A PTA visit note, dated 3/18/13 at 2:52 PM documented Patient #2's oxygen saturation of 86%. The note did not indicate if Patient #2 was on oxygen at the time of the reading.</p> <p>The PTA visit note did not contain evidence of communication with the nurse that the low oxygen saturation level had been obtained.</p> <p>A nursing visit note, dated 3/28/13 at 10:08 PM documented "...Gave pt her Arenesp injection,</p>	G 158	Please refer to the attached Appendix I for all plans of correction.	

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G 158	<p>Continued From page 14 and B-12 injection, pt tol injections well." The note did not indicate the site or dosage of the injections.</p> <p>The medical record did not contain evidence of physician orders for administration of Arenesp or B-12 injections.</p> <p>The physician was not contacted for medication clarification orders or for notification of low oxygen saturation readings.</p> <p>During an interview on 4/02/13 at 10:00 AM, the Administrator stated the tablet device the staff used for documentation was pre-set with vital sign parameters. She stated the oxygen saturation low parameter was set for 88%. The Administrator stated the nursing staff would be able to adjust the pre-set levels but would need to document the change with a physician order. She reviewed Patient #2's record and was not able to find a physician order for accepting lower levels.</p> <p>The RN Case Manager for Patient #2 was interviewed on 4/03/13 at 12:30 PM. After review of the record, the RN stated she had adjusted the limits on her tablet device to accept lower oxygen sats to 85%. She stated Patient #2's daughter had provided to her a copy of prescriptions for B-12 as well as Arenesp. She stated the medications for Patient #2 had been ordered by another physician, not the physician who was listed as the attending physician on the POT. The RN confirmed she administered the medications without clarification from the attending physician.</p>	G 158	Please refer to the attached Appendix I for all plans of correction.	

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G 158	<p>Continued From page 15</p> <p>Patient #2's physician was not contacted for medication clarification orders or for notification of low oxygen saturation readings.</p> <p>c. Patient #5 was a 91 year old female admitted to the agency on 1/21/12 for nursing and therapy services related to muscle weakness, dementia, and gait abnormality. The POT for the certification period 1/21/12 to 3/20/12 included orders for SN once a week for 3 weeks, PT 3 times over the first 10 days, then twice a week for 2 weeks. HHA services were ordered twice weekly for 8 weeks. Patient #5 was discharged from PT and Home Health services on 2/27/12. The POT was signed by Patient #5's physician 2/07/12.</p> <p>The SOC assessment did not document communication with Patient #5's physician to inform of the POT and receive orders for care.</p> <p>During an interview on 4/02/13 at 12:00 PM, the Administrator reviewed Patient #5's medical record and confirmed the physician had not been notified to discuss the POT and receive orders. The Administrator stated the agency would send the physician a communication note which included the POT information to be signed before the POT was developed. The Administrator stated the RN who performed the SOC would not routinely contact the physician directly for verbal orders.</p> <p>Patient #5's physician was not contacted after the admission assessment for orders.</p> <p>d. Patient #4 was a 77 year old male admitted to the agency on 9/27/12 for nursing and therapy</p>	G 158	Please refer to the attached Appendix I for all plans of correction.		

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G 158	<p>Continued From page 16</p> <p>services related to diabetes and hypertension. The POT for the certification period 9/27/12 to 11/25/12 included orders for SN 2 times a week for 4 weeks, and PT for 3 times a week for 3 weeks.</p> <p>The SOC assessment, dated 9/27/12 at 10:15 AM, documented Patient #4 had a skin tear on his right knee after a fall. The nurse noted the wound had purulent yellow drainage, and she provided wound care. There was no indication of physician notification regarding the wound, or to receive orders for wound care. In addition, the SOC assessment noted Patient #4 was on oxygen by nasal cannula at 2 liters per minute. The POT did not include oxygen therapy or wound care.</p> <p>A "SN Routine Visit" note, dated 10/01/12 at 12:45 PM, documented "pt (patient) states last BG (blood glucose) was 410 this am and has come down to 260 during visit. Pt (patient) feels confused and tired." According to diabetes.org, normal range for blood sugar is 70-100. In addition, the RN documented "SN assessed and adm (administered) wound care to right knee." The record did not include details of the wound care provided or indicate the physician had been notified of the high blood sugar results.</p> <p>A "SN OASIS-C" note, dated 10/16/12 at 3:45 PM, documented Patient #4 had a blood sugar level of 202. The RN noted "...in to see pt for home health visit and to discharge pt from services." There was no indication the nurse contacted the physician to inform of the elevated blood sugar level or to receive discharge instructions.</p>	G 158	<p>Please refer to the attached Appendix I for all plans of correction.</p>		

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G 158	Continued From page 17 In an interview on 4/02/13 at 1:35 PM, the Administrator reviewed Patient #4's medical record and confirmed there was a lack of clarity related to informing the physician of the wound as well as the elevated blood sugar results. The nurse provided care to Patient #4 that was not included on the POT. Patient care was provided to patients that were not included in the written plan of care.	G 158	Please refer to the attached Appendix I for all plans of correction.		
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, agency policies, patient and staff interview, and observation, it was determined the agency failed to ensure the plan of care included all pertinent information for 1 of 6 patients (#1) whose records were reviewed. This had the potential to interfere with continuity and completeness of patient care. Findings include: A policy, titled "PLAN OF CARE 485," dated 12/01/97 and reviewed January 2013, stated "The	G 159			

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G 159	<p>Continued From page 18</p> <p>patients [sic] plans of care will include at least: ...diagnosis, types of services and equipment required, frequency of visits, medications, treatments."</p> <p>1. Patient #1 was a 72 year old female whose SOC was 9/22/10. Her diagnoses included MS (Multiple Sclerosis) and neurogenic bladder (a dysfunction of the urinary bladder due to disease of the central nervous system). The POT for the certification periods 1/09/13 to 3/09/13 and 3/10/13 to 5/08/13 included orders for SN services for catheter change and assessment. The medical record was reviewed and contained incomplete and unclear information related to Patient #1 as follows:</p> <p>a. Both POT's included a diagnosis of Multiple Sclerosis, but did not include the following interventions, DME, and medications:</p> <ul style="list-style-type: none"> - Skilled nursing notes from 1/17/13 to 4/03/13 were reviewed. The notes included documentation of obtaining a INR result on 2/13/13, 2/18/13, and 3/29/13. The physician was not notified of the results, and the POTs did not include orders for the tests. - The SN documented administration of a bladder irrigation on 2/18/13, 2/25/13, 3/01/13, 3/05/13, and 4/03/13. The orders for the irrigation and the solution was not included on the POTs. -During a home visit on 4/03/13 from 8:00 to 9:30 AM, DME used by Patient #1 was identified. Equipment noted included a wheelchair, Hoyer lift, shower chair, toilet seat rails, or a PT/INR machine. The DME was not included on the 	G 159	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 159	Continued From page 19 POTs. The RN Case Manager was interviewed on 4/03/13 beginning at 2:10 PM. She reviewed Patient #1's record and confirmed she had provided bowel care, wound care and blood testing that had not been ordered on the POTs. The RN Case Manager confirmed the DME in Patient #1's home had not been included in the POTs.	G 159	Please refer to the attached Appendix I for all plans of correction.	
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 and agency policy and staff interview, it was determined the agency failed to ensure a physician was consulted to approve the plan of care for 6 of 6 patients (#1-6) whose records were reviewed. This resulted in plans of care that were developed and initiated without appropriate physician approval. Findings include: 1. A policy, titled "PLAN OF CARE 485," dated 12/01/97 and reviewed January 2013, stated "The plan of care must be authorized in writing based on an evaluation of the patients [sic] immediate and long-term needs." This process did not clearly occur as follows:	G 160		

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G 160	<p>Continued From page 20</p> <p>a. Patient #1 was a 72 year old female with a SOC of 9/22/10. A Recertification assessment was performed on 3/05/13. There was no documentation of a verbal or written order after the assessment that indicated the physician was consulted to approve the POT.</p> <p>The physician was not consulted to approve the POT.</p> <p>b. Patient #2 was a 86 year old female with a SOC of 3/07/13. There was no documentation of a verbal or written order after the admission assessment that indicated the physician was consulted to approve the POT.</p> <p>The physician was not consulted to approve the POT.</p> <p>c. Patient #3 was a 89 year old female with a SOC of 1/09/13. There was no documentation of a verbal or written order after the admission assessment that indicated the physician was consulted to approve the POT.</p> <p>The physician was not consulted to approve the POT.</p> <p>d. Patient #4 was a 77 year old male with a SOC of 9/27/12. There was no documentation of a verbal or written order after the admission assessment that indicated the physician was consulted to approve the POT.</p> <p>The physician was not consulted to approve the POT.</p>	G 160	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 160	Continued From page 21 e. Patient #5 was a 91 year old female with a SOC of 1/21/12. There was no documentation of a verbal or written order after the admission assessment that indicated the physician was consulted to approve the POT. The physician was not consulted to approve the POT. f. Patient #6 was a 87 year old female with a SOC of 1/14/13. There was no documentation of a verbal or written order after the admission assessment that indicated the physician was consulted to approve the POT. The physician was not consulted to approve the POT. During an interview on 4/02/13 at 12:00 PM, the Administrator reviewed Patient #1-6's medical records and confirmed the physicians had not been notified after the initial patient assessment to discuss the POT's and receive orders. The Administrator stated the agency's practice was to send each physician a communication note after the SOC or recertification assessment which would include any orders before the POT was developed and submitted. Physicians were not directly contacted to discuss the POT and obtain orders after the admission/recertification assessments were conducted.	G 160	Please refer to the attached Appendix I for all plans of correction.	
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		

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G 164	<p>Continued From page 22 alter the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records and policies, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the plan of care for 3 of 6 patients (#1, #2, and #4) whose records were reviewed. This resulted in missed opportunity for physicians to alter the POT to meet patient needs. Findings include:</p> <p>A policy, titled "PLAN OF CARE 485," dated 12/01/97 and reviewed January 2013, stated "If the patient's condition changes are severe enough to change or alter the plan of care, the physician will be alerted by the staff." This policy was not followed. Examples include:</p> <p>1. Patient #1 was a 72 year old female whose SOC was 9/22/10. Her diagnoses included MS (Multiple Sclerosis) and neurogenic bladder (a dysfunction of the urinary bladder due to disease of the central nervous system).</p> <p>Patient #1 was seen by a physician on 2/12/13 and a blood clot was identified in her left leg. Her record contained a verbal order from a physician (a different physician from the one included on the POT), for Lovenox 80 mg to be administered sub-cutaneously twice daily until her INR was >2. INR (international normalized ratio) is a test to determine the clotting tendency of blood, with a target range of 2-3.</p> <p>On a "Visit Note Report," dated 2/13/13 at 7:51</p>	G 164	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 164	<p>Continued From page 23</p> <p>PM the RN documented she taught the family to administer Lovenox injection for a new onset diagnosis of DVT (deep vein thrombus, or "blood clot") in Patient #1's left leg. The RN documented the family had taken measurements of the calf, foot and thigh. The RN had not measured or documented measurements of Patient #1's foot, thigh and calf, although she noted "profound unilateral swelling."</p> <p>There was no communication with the attending physician to inform of the blood clot, the orders for the Lovenox injections, or of the INR testing. There was no indication on the POT that the attending physician was aware of an additional medical provider for Patient #1.</p> <p>On 2/18/13, the SN visit note indicated she obtained an INR result of 2.7, the result was called to a physician, and the Lovenox was discontinued. The RN did not indicate which physician was notified of the INR. The RN did not document the appearance of Patient #1's left leg with the blood clot.</p> <p>On 2/25/13 at 8:08 AM, a SN visit note documented a wound on Patient #1's left knee to which she provided wound care. The nurse did not notify the physician about the wound.</p> <p>On 2/27/13 at 8:11 AM, a SN visit note documented 4+ edema on Patient #1's lower left leg. There was no documentation of the appearance of her left knee wound that was identified the previous visit. The physician was not notified of the edema in the leg with the blood clot.</p>	G 164	Please refer to the attached Appendix I for all plans of correction.		

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G 164	<p>Continued From page 24</p> <p>On 3/01/13 at 8:04 AM, a SN visit note documented Patient #1 had a wound on her right knee with serous exudate, and moderate amount of granulation tissue. The visit note on 2/25/13 had identified a wound on the left knee. There was no indication in Patient #1's record that her physician had been notified of the wound.</p> <p>On 3/05/13 at 8:07 AM, a SN visit/recertification assessment documented a wound on Patient #1's left knee. In addition, her left leg was noted to have 4+ edema. The RN documented she provided wound care to Patient #1's left knee pressure ulcer wound. There was no indication in Patient #1's record that her physician had been notified of the wound.</p> <p>On 3/25/13 at 8:02 AM, a SN visit note documented 4+ edema in Patient #1's left leg.</p> <p>On 3/27/13 at 8:08 AM, a SN visit note documented 3+ edema in Patient #1's left leg.</p> <p>On 3/29/13 at 8:20 AM, a SN visit note documented 3+ edema in Patient #1's left leg, and she wrapped the leg with coban. In addition, the RN noted she obtained an INR result of 1.4, and instructed Patient #1's family to report the results to the physician. The RN did not communicate the treatment of the edema or the results of the INR to the physician.</p> <p>On 4/01/13 at 8:21 AM, a SN visit note documented 4+ edema in Patient #1's left leg, but no measurements were recorded. The nurse did not notify the physician of the edema.</p> <p>The RN Case Manager was interviewed on</p>	G 164	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 164	<p>Continued From page 25</p> <p>4/03/13 beginning at 2:10 PM. She reviewed Patient #1's record and confirmed she noted marked edema in the leg with the blood clot, as well as the wound and the provision of wound care. The RN stated the physician who was managing the blood clot was not the physician listed as the attending on the POT. She stated the physician on the POT was a urologist, and the physician managing the blood clot was a family practitioner.</p> <p>The physician for Patient #1 was not alerted to changes in her condition.</p> <p>2. Patient #2 was an 86 year old female admitted to the agency on 3/07/13 for nursing and therapy services related to muscle weakness, CKD, and CHF. The POT for the certification period 3/07/13 to 5/05/13 included orders for SN, PT, OT, and HHA services.</p> <p>a. The POT included under Section 22, (Goals/Rehabilitation Potential/Discharge Plans), "Abnormal O2 (oxygen) saturations will be reported to physician." The record indicated Patient #2 had episodes of low oxygen saturations. Oxygen saturation levels as defined in "Procedure Manual for Critical Care, Fourth Edition," indicate the percentage of hemoglobin saturated with oxygen. A normal value would be 97% to 99% in a healthy individual. Values under 90% would be considered low. There was no documentation of communication between the Case Manager and the physician related to Patient #2's low oxygen saturation levels as follows:</p> <p>-3/07/13 at 2:58 PM, the RN documented in her</p>	G 164	<p>Please refer to the attached Appendix I for all plans of correction.</p>		

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G 164	<p>Continued From page 26</p> <p>admission note Patient #2's oxygen saturation was 70%. The RN noted after Patient #2 rested for 30 minutes, her oxygen saturation improved to 86%. The RN wrote she would monitor for 1 week and contact the physician for orders as indicated. The record did not contain documentation the physician was notified.</p> <p>-3/18/13 at 3:08 PM, the PTA documented Patient #2's oxygen saturation was 86%. The RN had been in to visit Patient #2 earlier that day and did not record an oxygen saturation level. The record did not indicate the PTA notified the RN Case Manager of the low oxygen level. The physician was not notified of the low oxygen saturation level.</p> <p>During an interview on 4/03/13 at 12:30 PM, the RN Case Manager reviewed Patient #2's record and confirmed the documentation of low oxygen saturations. She stated she possibly monitored Patient #2's oxygen on 3/18/13 during her visit, but forgot to record it. The RN Case Manager stated the PTA did not notify her regarding the low saturation of 86%.</p> <p>The nurse did not notify Patient #2's physician of changes in her condition.</p> <p>3. Patient #4 was a 77 year old male admitted to the agency on 9/27/12 for nursing and therapy services related to diabetes and hypertension. The POT for the certification period 9/27/12 to 11/25/12 included orders for SN 2 times a week for 4 weeks, and PT for 3 times a week for 3 weeks.</p> <p>The SOC assessment, dated 9/27/12 at 10:15</p>	G 164	Please refer to the attached Appendix I for all plans of correction.	

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G 164	<p>Continued From page 27</p> <p>AM, documented Patient #4 had a skin tear on his right knee after a fall. The nurse noted the wound had purulent yellow drainage, and she provided wound care. There was no indication of physician notification regarding the wound, or to receive orders for wound care. In addition, the SOC assessment noted Patient #4 was on oxygen by nasal cannula at 2 liters per minute. The POT did not include oxygen therapy or wound care.</p> <p>A "SN Routine Visit" note, dated 10/01/12 at 12:45 PM, documented "pt (patient) states last BG (blood glucose) was 410 this am and has come down to 260 during visit. Pt (patient) feels confused and tired." According to diabetes.org, normal range for blood sugar is 70-100. In addition, the RN documented "SN assessed and adm [administered] wound care to right knee." The record did not include details of the wound care provided or indicate the physician had been notified of the high blood sugar results.</p> <p>A "SN OASIS-C" note, dated 10/16/12 at 3:45 PM, documented Patient #4 had a blood sugar level of 202. The RN noted "...in to see pt for home health visit and to discharge pt from services." There was no indication the nurse contacted the physician to inform of the elevated blood sugar level or to receive discharge instructions.</p> <p>In an interview on 4/02/13 at 1:35 PM, the Administrator reviewed Patient #4's medical record and confirmed there was a lack of clarity related to informing the physician of the wound as well as the elevated blood sugar results.</p>	G 164	<p>Please refer to the attached Appendix I for all plans of correction.</p>		

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G 164	Continued From page 28 The nurse did not notify Patient #4's physician of changes in his medical status.	G 164	Please refer to the attached Appendix I for all plans of correction.	
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure physician orders were obtained/clarified prior to the provision of wound care and medication administration for 3 of 6 patients (#1, #2, and #4) whose records were reviewed. This resulted in unauthorized medication administration and wound care and had the potential to negatively impact patient safety. Findings include: 1. Patient #1 was a 72 year old female whose SOC was 9/22/10. Her diagnoses included MS (Multiple Sclerosis) and neurogenic bladder (a dysfunction of the urinary bladder due to disease of the central nervous system). Patient #1 was seen by a physician on 2/12/13 and a blood clot was identified in her left leg. Her record contained a verbal order from a physician (a different physician from the one included on the POT), for Lovenox 80 mg to be administered sub-cutaneously twice daily until her INR was >2. INR (international normalized ratio) is a test to determine the clotting tendency of blood, with a target range of 2-3.	G 165		

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G 165	<p>Continued From page 29</p> <p>A "Visit Note Report," dated 2/13/13 at 7:51 PM the RN documented she taught the family to administer Lovenox injection for a new onset diagnosis of DVT (deep vein thrombus, or "blood clot") in Patient #1's left leg.</p> <p>There was no communication with the attending physician to inform of the blood clot, the orders for the Lovenox injections, or of the INR testing. There was no indication on the POT that the attending physician was aware of an additional medical provider for Patient #1.</p> <p>On 2/18/13, the SN visit note indicated she obtained an INR result of 2.7, the result was called to a physician, and the Lovenox was discontinued. The RN did not indicate which physician was notified of the INR.</p> <p>On 2/25/13 at 8:08 AM, a SN visit note documented a wound on Patient #1's left knee, to which she provided wound care. The nurse provided wound care without a physician order.</p> <p>On 3/05/13 at 8:07 AM, a SN visit/recertification assessment documented a wound on Patient #1's left knee. In addition, her left leg was noted to have 4+ edema. The RN documented she provided wound care to Patient #1's left knee pressure ulcer wound. The nurse provided wound care without a physician order.</p> <p>On 3/29/13 at 8:20 AM, a SN visit note documented 3+ edema in Patient #1's left leg, and she wrapped the leg with coban. In addition, the RN noted she obtained an INR result of 1.4, and instructed Patient #1's family to report the</p>	G 165	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 165	<p>Continued From page 30</p> <p>results to the physician. The nurse provided wound care and diagnostic testing without a physician order.</p> <p>The RN Case Manager was interviewed on 4/03/13 beginning at 2:10 PM. She reviewed Patient #1's record and confirmed she had provided wound care. The RN stated the physician who was managing the blood clot was not the physician listed as the attending on the POT. She stated the physician on the POT was a urologist, and the physician managing the blood clot was a family practitioner.</p> <p>Patient #1 received medications and treatments that had not been ordered by the physician on the POT.</p> <p>2. Patient #2 was an 86 year old female admitted to the agency on 3/07/13 for nursing and therapy services related to muscle weakness, chronic kidney disease, and congestive heart failure. The POT for the certification period 3/07/13 to 5/05/13 included orders for SN, PT, OT, and HHA services.</p> <p>On a "Visit Note Report," dated 3/11/13 at 2:25 PM, the SN documented she had called a pharmacy company for pre-authorization of Aranesp (an injectable medication used to treat anemia). There was no indication the nurse had communicated with Patient #2's physician to receive orders for administration of the medication.</p> <p>On a "Visit Note Report," dated 3/15/13 at 1:52 PM, the nurse documented she administered Aranesp to Patient #2, although she did not</p>	G 165	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 165	<p>Continued From page 31 record the dose, route, or site of injection.</p> <p>On a "Visit Note Report," dated 3/28/13 at 10:08 PM, the nurse documented she administered Aranesp to Patient #2, although she did not record the dose, route, or site of injection.</p> <p>During an interview on 4/03/13 at 12:30 PM, the RN Case Manager reviewed Patient #2's record and confirmed she had administered Aranesp injections. She stated Patient #2 was admitted under the care of a family practice physician, and the medication for anemia had been ordered by her "kidney" doctor. The RN confirmed she had not contacted the physician listed on the POT regarding the medication. She stated Patient #2 had the prescription, she assisted her with obtaining the medication, and administered it.</p> <p>Patient #2 received medications and treatments that had not been ordered by the physician on the POT.</p> <p>3. Patient #4 was a 77 year old male admitted to the agency on 9/27/12 for nursing and therapy services related to diabetes and hypertension. The POT for the certification period 9/27/12 to 11/25/12 included orders for SN 2 times a week for 4 weeks, and PT for 3 times a week for 3 weeks.</p> <p>The SOC assessment, dated 9/27/12 at 10:15 AM, documented Patient #4 had a skin tear on his right knee after a fall. The nurse noted the wound had purulent yellow drainage, and she provided wound care. There was no indication of physician notification regarding the wound, or to receive orders for wound care. In addition, the</p>	G 165	<p>Please refer to the attached Appendix I for all plans of correction.</p>		

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G 165	<p>Continued From page 32</p> <p>SOC assessment noted Patient #4 was on oxygen by nasal cannula at 2 liters per minute. The POT did not include oxygen therapy or wound care.</p> <p>A "SN Routine Visit" note, dated 10/01/12 at 12:45 PM, documented "pt (patient) states last BG (blood glucose) was 410 this am and has come down to 260 during visit. Pt (patient) feels confused and tired." According to diabetes.org, normal range for blood sugar is 70-100. In addition, the RN documented "SN assessed and adm (administered) wound care to right knee." The record did not include details of the wound care provided or indicate the physician had been notified of the high blood sugar results.</p> <p>A "SN OASIS-C" note, dated 10/16/12 at 3:45 PM, documented Patient #4 had a blood sugar level of 202. The RN noted "...in to see pt for home health visit and to discharge pt from services." There was no indication the nurse contacted the physician to inform of the elevated blood sugar level or to receive discharge instructions.</p> <p>In an interview on 4/02/13 at 1:35 PM, the Administrator reviewed Patient #4's medical record and confirmed there was a lack of clarity related to informing the physician of the elevated blood sugar results and obtaining wound care orders.</p> <p>Patient #4 received medications and treatments that had not been ordered by the physician.</p> <p>Medications, wound care, and treatments were provided to patients without physician orders.</p>	G 165	Please refer to the attached Appendix I for all plans of correction.	

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G 168	<p>484.30 SKILLED NURSING SERVICES</p> <p>This CONDITION is not met as evidenced by: Based on staff interview, review of patients' clinical records and review of agency policies, it was determined the agency failed to develop and/or modify patients' POC's. Further, the agency staff failed to ensure that staff informed the physician of changes in patients' conditions. The findings include:</p> <ol style="list-style-type: none"> 1. Refer to G170 as it relates to the agency's failure to ensure that nursing services were provided in accordance with the POT. 2. Refer to G176 as it relates to the agency's failure to alert the physician of changes in the patients' conditions. <p>The cumulative effect of these deficient practices impeded the agency's ability to provide nursing services necessary to meet patients' needs.</p>	G 168	Please refer to the attached Appendix I for all plans of correction.	
G 170	<p>484.30 SKILLED NURSING SERVICES</p> <p>The HHA furnishes skilled nursing services in accordance with the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and review of medical records and policies, it was determined the agency failed to ensure nursing services were provided in accordance with the POT for 3 of 6 patients (#1, #2, and #4) whose records were reviewed. Failure to follow the established POT had the potential to result in negative patient outcomes. Findings include:</p>	G 170		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/04/2013
NAME OF PROVIDER OR SUPPLIER REXBURG HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 280 EAST MAIN STREET REXBURG, ID 83440	
(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 170	Continued From page 34 A policy, titled "PLAN OF CARE 485," dated 12/01/97 and reviewed January 2013, included "The plan of care must be authorized in writing based on an evaluation of the patients [sic] immediate and long-term needs. It will include at least: ...diagnosis, types of services and equipment required, medications, treatments." This process did not clearly occur as described in the examples that follow: Nursing services which included wound care, blood tests, and medication administration for the following patients was provided that had not been included in the POT: 1. Patient #1 was a 72 year old female whose SOC was 9/22/10. Her diagnoses included MS (Multiple Sclerosis) and neurogenic bladder (a dysfunction of the urinary bladder due to disease of the central nervous system). Patient #1 was seen by a physician on 2/12/13 and a blood clot was identified in her left leg. Her record contained a verbal order from a physician (a different physician from the one included on the POT), for Lovenox 80 mg to be administered sub-cutaneously twice daily until her INR was >2. INR (international normalized ratio) is a test to determine the clotting tendency of blood, with a target range of 2-3. On a "Visit Note Report," dated 2/13/13 at 7:51 PM the RN documented she taught the family to administer Lovenox injection for a new onset diagnosis of DVT (deep vein thrombus, or "blood clot") in Patient #1's left leg.	G 170	Please refer to the attached Appendix I for all plans of correction.	

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G 170	<p>Continued From page 35</p> <p>There was no communication with the attending physician to inform of the blood clot, the orders for the Lovenox injections, or of the INR testing. There was no indication the POT had been updated to include the medication and blood testing.</p> <p>On 2/18/13, the SN visit note indicated she obtained an INR result of 2.7, the result was called to a physician, and the Lovenox was discontinued. The RN did not indicate which physician was notified of the INR.</p> <p>On 2/25/13 at 8:08 AM, a SN visit note documented a wound on Patient #1's left knee to which she provided wound care. The nurse provided wound care, however, the POT had not been updated to include wound care.</p> <p>On 3/05/13 at 8:07 AM, a SN visit/recertification assessment documented a wound on Patient #1's left knee. In addition, her left leg was noted to have 4+ edema. The RN documented she provided wound care to Patient #1's left knee pressure ulcer wound. The nurse provided wound care that was not included in the POT.</p> <p>On 3/29/13 at 8:20 AM, a SN visit note documented 3+ edema in Patient #1's left leg, and she wrapped the leg with coban. In addition, the RN noted she obtained an INR result of 1.4, and instructed Patient #1's family to report the results to the physician. The nurse provided wound care and diagnostic tests although it was not in accordance with the POT.</p> <p>The RN Case Manager was interviewed on 4/03/13 beginning at 2:10 PM. She reviewed</p>	G 170	Please refer to the attached Appendix I for all plans of correction.	

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G 170	<p>Continued From page 36</p> <p>Patient #1's record and confirmed she had provided wound care and diagnostic tests. The RN confirmed she had not updated the POT to include wound care, INR testing, and updated medications.</p> <p>Patient #1 received medications and treatments that were not included on the POT</p> <p>2. Patient #2 was an 86 year old female admitted to the agency on 3/07/13 for nursing and therapy services related to muscle weakness, chronic kidney disease, and congestive heart failure. The POT for the certification period 3/07/13 to 5/05/13 included orders for SN, PT, OT, and HHA services.</p> <p>On a "Visit Note Report," dated 3/15/13 at 1:52 PM, the nurse documented she administered Aranesp to Patient #2, although she did not record the dose, route, or site of injection. The POT had not been updated to include the medication.</p> <p>On a "Visit Note Report," dated 3/28/13 at 10:08 PM, the nurse documented she administered Aranesp to Patient #2, although she did not record the dose, route, or site of injection. The POT had not been updated to include the medication.</p> <p>During an interview on 4/03/13 at 12:30 PM, the RN Case Manager reviewed Patient #2's record and confirmed she had administered Aranesp injections. She stated Patient #2 was admitted under the care of a family practice physician, and the medication for anemia had been ordered by her "kidney" doctor. The RN confirmed she had</p>	G 170	Please refer to the attached Appendix I for all plans of correction.	

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G 170	<p>Continued From page 37</p> <p>not contacted the physician listed on the POT regarding the medication. She confirmed she had not updated the POT to include the medication.</p> <p>Patient #2 received medication that had not been included on the POT.</p> <p>3. Patient #4 was a 77 year old male admitted to the agency on 9/27/12 for nursing and therapy services related to diabetes and hypertension. The POT for the certification period 9/27/12 to 11/25/12 included orders for SN 2 times a week for 4 weeks, and PT for 3 times a week for 3 weeks.</p> <p>The SOC assessment, dated 9/27/12 at 10:15 AM, documented Patient #4 had a skin tear on his right knee after a fall. The nurse noted the wound had purulent yellow drainage, and she provided wound care. There was no indication of physician notification regarding the wound, or to receive orders for wound care. In addition, the SOC assessment noted Patient #4 was on oxygen by nasal cannula at 2 liters per minute. The POT did not include oxygen therapy or wound care.</p> <p>A "SN Routine Visit" note, dated 10/01/12 at 12:45 PM, documented "pt (patient) states last BG (blood glucose) was 410 this am and has come down to 260 during visit. Pt (patient) feels confused and tired." According to diabetes.org, normal range for blood sugar is 70-100. In addition, the RN documented "SN assessed and adm (administered) wound care to right knee." The record did not include details of the wound care provided or indicate the physician had been</p>	G 170	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 170	Continued From page 38 notified of the high blood sugar results. A "SN OASIS-C" note, dated 10/16/12 at 3:45 PM, documented Patient #4 had a blood sugar level of 202. The RN noted "...in to see pt for home health visit and to discharge pt from services." There was no indication the nurse contacted the physician to inform of the elevated blood sugar level or to receive discharge instructions. In an interview on 4/02/13 at 1:35 PM, the Administrator reviewed Patient #4's medical record and confirmed there was a lack of clarity related to informing the physician of the elevated blood sugar results and obtaining wound care orders. Patient #4 received medication and treatments that had not been included on the POT. Patients received services that were not included on the POTs.	G 170	Please refer to the attached Appendix I for all plans of correction.	
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the registered nurse coordinated services and informed the physician of changes in patients' conditions and needs for 3 of 6 patients (#2, #4,	G 176		

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G 176	<p>Continued From page 39 and #5) whose records were reviewed. This had the potential to result in unmet patient needs and negatively impact continuity and quality of patient care. Findings include:</p> <p>A policy titled "MULTI DISCIPLINARY COMMUNICATION," reviewed January 2013, included: "all personnel who are contributing to the patients' care will coordinate said care through case conferences, communication notes, plans of care and the medical record to ensure that all patients receive the highest quality of care." Coordination of patient care was not noted as follows:</p> <p>1. Patient #2 was an 86 year old female admitted to the agency on 3/07/13 for nursing and therapy services related to muscle weakness, CKD, and CHF. The POT for the certification period 3/07/13 to 5/05/13 included orders for SN 2 times a week for 1 week and 1 time a week for 2 weeks. PT was ordered 1 time a week for 1 week, and 2 times a week for 7 weeks. OT was ordered 2 times a week for 4 weeks.</p> <p>Visit notes for Patient #2 from 3/07/13 to 4/02/13 were reviewed for documentation of coordination of care. There were a total of 5 nursing visits and 16 therapy visits.</p> <p>a. The POT included under Section 22, (Goals/Rehabilitation Potential/Discharge Plans), "Abnormal O2 (oxygen) saturations will be reported to physician." The record indicated Patient #2 had episodes of low oxygen saturations. Oxygen saturation levels as defined in "Procedure Manual for Critical Care, Fourth Edition," indicate the percentage of hemoglobin</p>	G 176	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 176	<p>Continued From page 40</p> <p>saturated with oxygen. A normal value would be 97% to 99% in a healthy individual. Values under 90% would be considered low. There was no documentation of communication between the Case Manager and the therapy disciplines of monitoring for evidence of respiratory distress or her need for supplemental oxygen as follows:</p> <p>-3/07/13 at 2:58 PM, the RN documented in her admission note Patient #2's oxygen saturation was 70%. The RN noted after Patient #2 rested for 30 minutes, her oxygen saturation improved to 86%. The RN wrote she would monitor for 1 week and contact the physician for orders as indicated. The record did not contain documentation the physician was notified.</p> <p>-3/18/13 at 3:08 PM, the PTA documented Patient #2's oxygen saturation was 86%. The RN had been in to visit Patient #2 earlier that day and did not record an oxygen saturation level. The record did not indicate the PTA notified the RN Case Manager of the low oxygen level.</p> <p>During an interview on 4/03/13 at 12:30 PM, the RN Case Manager reviewed Patient #2's record and confirmed the documentation of low oxygen saturations. The RN Case Manager stated the PTA did not notify her regarding the low saturation of 86% and she did not notify the physician of the low saturations.</p> <p>The RN Case Manager did not coordinate Patient #2's care.</p> <p>2. Patient #5 was a 91 year old female admitted to the agency on 1/21/12 for nursing and therapy services related to muscle weakness, dementia,</p>	G 176	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 176	<p>Continued From page 41 and gait abnormality. The POT for the certification period 1/21/12 to 3/20/12 included orders for SN once a week for 3 weeks, PT 3 times over the first 10 days, then twice a week for 2 weeks. HHA services were ordered twice weekly for 8 weeks.</p> <p>Visit notes for Patient #5 from 1/21/12 to 2/27/12 were reviewed for documentation of coordination of care. There was a total of 2 nursing visits and 9 therapy visits, and no documentation of interdisciplinary care coordination. The nursing visit note dated 1/26/12, included "...will do prn visits from here on out." There were no further nursing visits to Patient #5. The nursing note did not contain documentation of communication with the physical therapist that stated the physical therapist would be the only skilled discipline following Patient #5. The delegation of HHA supervisory duties was not clear. Patient #5 received Home Health services for 5 weeks with a single HHA supervisory visit, dated 2/08/12.</p> <p>In an interview on 4/03/13 at 11:50 AM, the Administrator reviewed Patient #5's medical record and confirmed there was no documentation by the RN case manager of transitioning patient care to PT. She confirmed an additional HHA supervisory visit by the RN case manager should have occurred. The Administrator stated HHA supervisory visits were performed by the RN case manager, and not delegated to the PT.</p> <p>The Case Manager did not ensure coordination of care for Patient #5.</p> <p>3. Patient #4 was a 77 year old male admitted to</p>	G 176	Please refer to the attached Appendix I for all plans of correction.		

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G 176	Continued From page 42 the agency on 9/27/12 for nursing and therapy services related to generalized muscle weakness and type II diabetes. The POT for the certification period 9/27/12 to 11/25/12 included orders for skilled nursing one time the first week, 2 times a week for 4 weeks, and PT 3 times a week for 4 weeks. Visit notes for Patient #4 from 9/27/12 to 10/16/12 were reviewed for documentation of coordination of care between the disciplines. There was a total of 6 RN visits and 4 PT visits, and no documentation of interdisciplinary care coordination. The PT visit note dated 10/15/12 documented Patient #4 would be moving to another state for the winter, and would be discharged from therapy services at that time. There was no documentation of communication with the physician or of the RN Case Manager. A "SN OASIS-C Discharge" note, dated 10/16/12, documented "SN into see pt for home health visit and to discharge pt from services." The record did not contain evidence the RN communicated with the PT or Patient #4's physician for discharge orders. In an interview on 4/02/13 at 1:35 PM, the Administrator reviewed Patient #4's medical record and confirmed there was no documentation of coordination of care. The RN Case Manager did not coordinate Patient #4's care with the physician and other disciplines. Coordination of care was not documented.	G 176	Please refer to the attached Appendix I for all plans of correction.		
G 235	484.48 CLINICAL RECORDS	G 235			

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G 235	Continued From page 43 This CONDITION is not met as evidenced by: Based on interview and review of clinical records and policies and procedures, it was determined that the HHA failed to ensure clinical records were maintained in accordance with accepted professional standards. This resulted in a record keeping system that did not accurately reflect current comprehensive patient information. The findings include: 1. Refer to G236 as it relates to the facility's failure to ensure patient records included accurate comprehensive identifying information. 2. Refer to G303 as it relates to the failure of the agency to complete a discharge summary. The cumulative effect of these deficient systemic practices resulted in the agency's inability to ensure effective, efficient, and coordinated care. 484.48 CLINICAL RECORDS	G 235	Please refer to the attached Appendix I for all plans of correction.	
G 236	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 record review and staff interview, it	G 236		

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G 236	<p>Continued From page 44</p> <p>was determined the agency failed to ensure complete and accurate documentation for 4 of 6 patients (#1, #2, #4, and #5) whose records reviewed. This had the potential to interfere with clarity, coordination, and safety of care. Findings include:</p> <p>The "CLINICAL RECORD" policy, reviewed January 2013, stated "Each record will contain ...Physician's name, Drugs, Treatments, Copies of summary reports, Discharge summary."</p> <p>However, patient records did not contain complete and accurate documentation as follows:</p> <p>1. Patient #1 was a 72 year old female whose SOC was 9/22/10. Her diagnoses included MS (Multiple Sclerosis) and neurogenic bladder (a dysfunction of the urinary bladder due to disease of the central nervous system). The POT for the certification period 1/09/13 to 3/09/13 included orders for SN services for catheter change and assessment.</p> <p>The medical record included orders from a physician who was not the attending physician on the POT for Patient #1. The medical record did not contain documentation the attending physician was aware of an additional physician managing her care related to the blood clot.</p> <p>Patient #1 was seen by a physician on 2/12/13 and a blood clot was identified in her left leg. Her record contained a verbal order from a physician (a different physician from the one included on the POT), for Lovenox 80 mg to be administered sub-cutaneously twice daily until her INR was >2. INR (international normalized ratio) is a test to</p>	G 236	Please refer to the attached Appendix I for all plans of correction.	

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G 236	<p>Continued From page 45</p> <p>determine the clotting tendency of blood, with a target range of 2-3.</p> <p>On a "Visit Note Report," dated 2/13/13 at 7:51 PM the RN documented she taught the family to administer Lovenox injection for a new onset diagnosis of DVT (deep vein thrombus, or "blood clot") in Patient #1's left leg. The RN documented the family had taken measurements of the calf, foot and thigh. The RN had not measured or documented measurements of Patient #1's foot, thigh and calf, although she noted "profound unilateral swelling."</p> <p>There was no communication with the attending physician to inform of the blood clot, the orders for the Lovenox injections, or of the INR testing. There was no indication on the POT that the attending physician was aware of an additional medical provider for Patient #1.</p> <p>On 2/18/13, the SN visit note indicated she obtained an INR result of 2.7, the result was called to a physician, and the Lovenox was discontinued. The RN did not indicate which physician was notified of the INR. The RN did not document the appearance of Patient #1's left leg with the blood clot.</p> <p>On 2/25/13 at 8:08 AM, a SN visit note documented a wound on Patient #1's left knee to which she provided wound care. The nurse did not notify the physician about the wound.</p> <p>On 3/01/13 at 8:04 AM, a SN visit note documented Patient #1 had a wound on her right knee with serous exudate, and moderate amount of granulation tissue. The visit note on 2/25/13</p>	G 236	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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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)
G 236	<p>Continued From page 46</p> <p>had identified a wound on the left knee. There was no indication in Patient #1's record that her physician had been notified of the wound.</p> <p>On 3/05/13 at 8:07 AM, a SN visit/recertification assessment documented a wound on Patient #1's left knee. In addition, her left leg was noted to have 4+ edema. The RN documented she provided wound care to Patient #1's left knee pressure ulcer wound. There was no indication in Patient #1's record that her physician had been notified of the wound.</p> <p>On 3/29/13 at 8:20 AM, a SN visit note documented 3+ edema in Patient #1's left leg, and she wrapped the leg with coban. In addition, the RN noted she obtained an INR result of 1.4, and instructed Patient #1's family to report the results to the physician. The RN did not communicate the treatment of the edema or the results of the INR to the physician. There were no orders to obtain the INR test.</p> <p>The RN Case Manager was interviewed on 4/03/13 beginning at 2:10 PM. She reviewed Patient #1's record and confirmed she noted marked edema in the leg with the blood clot, as well as the wound and the provision of wound care. The RN stated the physician who was managing the blood clot was not the physician listed as the attending on the POT. She stated the physician on the POT was a urologist, and the physician managing the blood clot was a family practitioner.</p> <p>Patient #1's medical record did not clearly indicate which physician was managing her care.</p>	G 236	<p>Please refer to the attached Appendix I for all plans of correction.</p>

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

PRINTED: 04/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137090	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/04/2013	
NAME OF PROVIDER OR SUPPLIER REXBURG HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 280 EAST MAIN STREET REXBURG, ID 83440		
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G 236	<p>Continued From page 47</p> <p>2. Patient #2 was an 86 year old female admitted to the agency on 3/07/13 for nursing and therapy services related to muscle weakness, CKD, and CHF. The POT for the certification period 3/07/13 to 5/05/13 included orders for SN, PT, OT, and HHA services.</p> <p>On a "Visit Note Report," dated 3/11/13 at 2:25 PM, the SN documented she had called a pharmacy company for pre-authorization of Aranesp (an injectable medication used to treat anemia). There was no indication the nurse had communicated with Patient #2's physician to receive orders for administration of the medication.</p> <p>On a "Visit Note Report," dated 3/15/13 at 1:52 PM, the nurse documented she administered Aranesp to Patient #2, although she did not record the dose, route, or site of injection.</p> <p>On a "Visit Note Report," dated 3/28/13 at 10:08 PM, the nurse documented she administered Aranesp to Patient #2, although she did not record the dose, route, or site of injection.</p> <p>During an interview on 4/03/13 at 12:30 PM, the RN Case Manager reviewed Patient #2's record and confirmed she had administered Aranesp injections. She stated Patient #2 was admitted under the care of a family practice physician, and the medication for anemia had been ordered by her "kidney" doctor. The RN confirmed she had not documented the information related to the medication administration in a clear manner.</p> <p>Patient #2's medical record lacked clear documentation of medication administration.</p>	G 236	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 236	<p>Continued From page 48</p> <p>3. Patient #4 was a 77 year old male admitted to the agency on 9/27/12 for nursing and therapy services related to diabetes and hypertension.</p> <p>The SOC assessment, dated 9/27/12 at 10:15 AM, documented Patient #4 had a skin tear on his right knee after a fall. The nurse noted the wound had purulent yellow drainage, and she provided wound care. There was no indication of physician notification regarding the wound, or to receive orders for wound care. In addition, the SOC assessment noted Patient #4 was on oxygen by nasal cannula at 2 liters per minute. The POT did not include oxygen therapy or wound care.</p> <p>A "SN Routine Visit" note, dated 10/01/12 at 12:45 PM, documented "pt states last BG [blood glucose] was 410 this am and has come down to 260 during visit. Pt feels confused and tired." According to diabetes.org, normal range for blood sugar is 70-100. In addition, the RN documented "SN assessed and adm [administered] wound care to right knee." The record did not include details of the wound care provided or indicate the physician had been notified of the high blood sugar results.</p> <p>A "SN OASIS-C" note, dated 10/16/12 at 3:45 PM, documented Patient #4 had a blood sugar level of 202. The RN noted "...in to see pt for home health visit and to discharge pt from services." There was no indication the nurse contacted the physician to inform of the elevated blood sugar level or to receive discharge instructions.</p>	G 236	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 236	<p>Continued From page 49</p> <p>In an interview on 4/02/13 at 1:35 PM, the Administrator reviewed Patient #4's medical record and confirmed there was a lack of clarity related to informing the physician of the wound as well as the elevated blood sugar results.</p> <p>Patient #4's medical record lacked clarity related to treatments and physician communication.</p> <p>4. Patient #5 was a 91 year old female admitted to the agency on 1/21/12 for nursing and therapy services related to muscle weakness, dementia, and gait abnormality. The POT for the certification period 1/21/12 to 3/20/12 included orders for SN once a week for 3 weeks, PT 3 times over the first 10 days, then twice a week for 2 weeks. HHA services were ordered twice weekly for 8 weeks.</p> <p>A nursing visit note dated 1/26/12, included "...will do prn visits from here on out." There were no further nursing visits to Patient #5. The nursing note did not contain documentation of communication with the physical therapist that stated the physical therapist would be the only skilled discipline following Patient #5. The delegation of HHA supervisory duties was not clear. One HHA supervisory visit was documented by the physical therapist, dated 2/08/12. Patient #5 received Home Health services for 5 weeks.</p> <p>In an interview on 4/03/13 at 11:50 AM, the Administrator reviewed Patient #5's medical record and confirmed there was no documentation by the RN case manager of transitioning patient care to the PT.</p>	G 236	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

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G 303	<p>Continued From page 51</p> <p>was 9/27/12. His diagnoses included diabetes and hypertension. He was discharged from the agency on 10/15/12. The record did not contain a discharge summary.</p> <p>3. Patient #5 was a 91 year old female whose SOC was 1/21/12. Her diagnoses included generalized muscle weakness and dementia. She was discharged from the agency on 2/27/12. The record did not contain a discharge summary.</p> <p>During an interview on 4/03/13 beginning at 10:00 AM, the Administrator reviewed the medical records of Patient's #3-5. She confirmed discharge summaries had not been completed and submitted to the physicians.</p> <p>The agency did not complete discharge summaries.</p>	G 303	<p>Please refer to the attached Appendix I for all plans of correction.</p>	

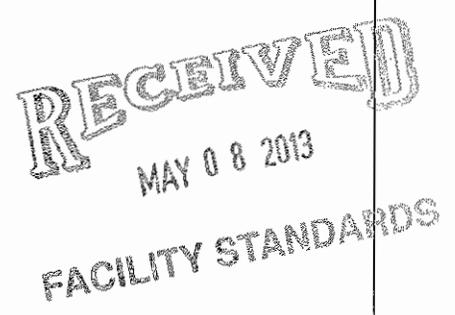
ID Prefix Tag	Provider's Plan of Correction	Responsible Individual	Monitoring Frequency	Date Corrected/ will be Corrected
G176	<p>The clinical software has been revised to provide easier and more comprehensive access to communications documentation. Staff have been inserviced to completely document all inter-disciplinary communications using these new tools.</p> <p>Clinical director will spot-check each clinician's communications notes on an ongoing basis to ensure staff compliance with this imperative.</p>	<p>Becky Staker RN</p> <p>Becky Staker RN</p>	<p>N/A</p> <p>Spot checks</p>	<p>05/08/13</p>
G235	<p>Please see response to Tags G236 and G303.</p>			
G236	<p>The agency has activated a module in the clinical software that allows listing of all physicians currently involved in a patient's care. Staff have been inserviced on the used of this module and the importance of including all physicians in this documentation.</p> <p>The attending physician will receive this information and be asked for approval for the other listed physicians to write orders and provide oversight as needed.</p> <p>The clinical director and case managers will audit 100% of admissions on a monthly basis for six months to ensure staff understanding and compliance</p>	<p>Becky Staker RN</p> <p>Becking Staker RN</p>	<p>N/A</p> <p>Monthly</p>	<p>05/08/13</p>
G303	<p>All staff have been instructed to include a discharge summary coordination note with all discharges, which triggers the clinical software to automatically forward a copy of the discharge summary to physicians upon patient discharge.</p> <p>The clinical director will audit 100% of discharges on a monthly basis for six months to ensure staff understanding and compliance</p>	<p>Becky Staker RN</p> <p>Becky Staker RN</p>	<p>N/A</p> <p>Monthly</p>	<p>05/01/13</p>

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001480	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/04/2013
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NAME OF PROVIDER OR SUPPLIER REXBURG HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 280 EAST MAIN STREET REXBURG, ID 83440
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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the Idaho state licensure survey of your agency. Surveyor conducting the review was: Susan Costa,RN,HFS Team Leader	N 000	<p>Please refer to the attached Appendix II for all plans of correction.</p> 	
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G144	N 062		
N 091	03.07024. SK.NSG.SERV. N091. The HHA furnishes nursing services by or under the supervision of a registered nurse in accordance with the plan of care. This Rule is not met as evidenced by: Refer to G170	N 091		
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	N 092		

Bureau of Facility Standards.....
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Administrative

(X6) DATE
5/9/2013

Bureau of Facility Standards

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N 092	Continued From page 1 by the assessments are addressed. A registered nurse performs the following: This Rule is not met as evidenced by: Refer to G176	N 092	Please refer to the attached Appendix II for all plans of correction.	
N 097	03.07024. SK. NSG. SERV. N097 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: e. Prepares clinical and progress notes, and summaries of care; This Rule is not met as evidenced by: Refer to G176	N 097		
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 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	N 152		
N 170	03.07030.04.PLAN OF CARE	N 170		

Bureau of Facility Standards

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N 170	Continued From page 2 N170 04. Initial Plan of Care. The initial plan of care and subsequent changes to the plan of care are approved by a doctor of medicine, osteopathy, or podiatric medicine. This Rule is not met as evidenced by: Refer to G160	N 170	Please refer to the attached Appendix II for all plans of correction.	
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G165	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:	N 174		

Bureau of Facility Standards

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N 174	Continued From page 3 Refer to G236	N 174	Please refer to the attached Appendix II for all plans of correction.	
N 185	03.07031.CLINICAL REC. N185 02. Contents. Clinical records must include: k. A discharge summary. This Rule is not met as evidenced by: Refer to G236	N 185		

Rexburg Home Health
Medicare Provider # 13-7090
State License Number HH170
April 4, 2013, 2000 Survey
State-Identified Deficiencies Credible Allegation

ID Prefix Tag	Provider's Plan of Correction	Responsible Individual	Monitoring Frequency	Date Corrected/ will be Corrected
N062	Please refer to POC on Federal response G144	N/A	N/A	N/A
N091	Please refer to POC on Federal response G170	N/A	N/A	N/A
N092	Please refer to POC on Federal response G176	N/A	N/A	N/A
N097	Please refer to POC on Federal response G176	N/A	N/A	N/A
N152	Please refer to POC on Federal response G158	N/A	N/A	N/A
N170	Please refer to POC on Federal response G160	N/A	N/A	N/A
N173	Please refer to POC on Federal response G165	N/A	N/A	N/A
N174	Please refer to POC on Federal response G236	N/A	N/A	N/A
N185	Please refer to POC on Federal response G236	N/A	N/A	N/A