



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
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CERTIFIED MAIL: 7007 3020 0001 4038 9864

May 22, 2014

Karla Jensen, Administrator
Helping Hands Home Health
1308 East Center
Pocatello, ID 83201

RE: Helping Hands Home Health, Provider #137102

Dear Ms. Jensen:

Based on the survey completed at Helping Hands Home Health, on May 8, 2014, by our staff, we have determined Helping Hands Home Health is out of compliance with the Medicare Home Health Agency (HHA) **Conditions of Participation of Acceptance of Patients, POC, Med Super (42 CFR 484.18) and Home Health Aide Services (42 CFR 484.36)**. To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused these conditions to be unmet, substantially limit the capacity of Helping Hands 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 Conditions 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;
- 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;

Karla Jensen, Administrator

May 22, 2014

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- 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 June 22, 2014. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than June 10, 2014.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **June 4, 2014.**

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

We urge you to begin correction immediately.

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

Sincerely,



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pmt
Enclosures

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

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

PRINTED: 05/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2014
NAME OF PROVIDER OR SUPPLIER HELPING HANDS HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1308 EAST CENTER POCATELLO, ID 83201	
(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 Medicare recertification survey of your home health agency conducted from 5/05/14 - 5/08/14. The surveyors conducting the recertification were:</p> <p>Susan Costa, RN, HFS - Team Leader Nancy Bax, RN, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>ALF - Assisted Living Facility BID - Two times per day BP - Blood Pressure cert - certification CHF - Congestive Heart Failure CNA - Certified Nurse Assistant COPD - Chronic Obstructive Pulmonary Disease CPR - Cardiopulmonary Resuscitation DM - Diabetes Mellitus DME - Durable Medical Equipment DON - Director of Nursing HHA - Home Health Agency HTN - Hypertension LPM - liters per minute LSW - Licensed Social Worker mg - milligrams mg/dL - milligrams per deciliter MSW - Medical Social Worker OASIS- Outcome Assessment Information Set OT - Occupational Therapy POC - Plan of Care PTA - Physical Therapy Aide PT - Physical Therapy RN - Registered Nurse ROC - Resumption of Care ROM - Range of Movement</p>	G 000	<p>RECEIVED</p> <p>JUN 20 2014</p> <p>FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Carla Jensen* TITLE *Administrator* (X6) DATE *6/3/2014*

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

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G 000	Continued From page 1 SN - Skilled Nursing SOC - Start of Care TED hose - Thrombo Embolic Deterrent (compression stockings) VS - Vital Signs wk - week	G 000	G.134 <u>Person Responsible:</u> Administrator <u>Plan of Correction:</u> The format for the home health aide program has been restructured to include a Home Health Aide Supplemental checklist upon new hires. Each home health aide will be given yearly competency and performance evaluations, and receive 12 hours of in service each year. The policy and procedure has been revised to reflect these changes.	
G 134	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. This STANDARD is not met as evidenced by: Based on staff interview and review of personnel records, it was determined the HHA failed to ensure the Administrator employed qualified personnel as evidenced by lack of documentation of current skills check list, annual inservice hours and annual evaluations for 11 of 11 home health aides (Staff A - K). These failures resulted in care being provided by potentially unqualified personnel. The findings include: 1. Refer to G212 as it relates to the failure of the agency to perform initial competency assessments for home health aides. 2. Refer to G213 as it relates to the failure of the agency to ensure the home health aides completed 12 hours of in-services each year and were evaluated for yearly competency. 3. Refer to G214 as it relates to the failure of the agency to provide annual performance review of competencies for home health aides.	G 134	<u>Description of improvement:</u> Competency and Performance evaluations, In-services/Education/ have been revised to coordinate the new employees duties, education and training. Employees will be instructed on using any resource material that is in their scope of service. Administrator and DON have in-serviced the nursing staff of the importance of training, continued education and monitoring of the C.N.A. With the new hires being educated and trained to the Medicare standards, and records kept current, the care for the clients will be more efficient and effective. <u>Date of Correction:</u> 06-10-2014 Refer to Exhibit: 1,2,3,4,5,6,7,8,9 <u>Refer to:</u> G212 Exhibit 1, 2 G213 Exhibit 5, 6 G214 Exhibit 7, 8 G215 Exhibit 3 G134 Addendum The office staff (employee #1) will take the initial information from the new employee or contracted employee. Employee #1 will create a file for the new employee. She will also log on a tracking Record information regarding, licenses, continuing education, CPR, competency & performance evaluations, security clearance, other ongoing information related to work requirements. Employee #2 will follow up monthly to Verify that all records are still current. Employee #3 will do a quarterly monitoring Of the records to make sure that all Records will be in compliance.	

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G 134	Continued From page 2	G 134		
G 143	<p>4. Refer to G215 as it relates to the failure of the agency to ensure home health aides received a minimum of 12 hours of in-service training annually.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES</p> <p>All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the agency failed to ensure care coordination between disciplines for 2 of 13 patients (#8 and #14) who received services from more than one discipline and whose records were reviewed. This interfered with quality and continuity of patient care. Findings include:</p> <p>1. Patient #14 was an 81 year old male who was admitted to the agency on 4/03/14 for PT and SN services related to imbalance, weakness, Type II DM, and HTN.</p> <p>Patient #14's record included a typed note, dated 4/25/14, that was signed by Staff S, a physical therapist. The note included a stamp "RECEIVED APR 28 2014" and included documentation that Patient #14 tripped over a step stool in his kitchen. The document noted Patient #14 suffered abrasions to his nose and forehead. Additionally, Staff S noted he had attempted to contact the HHA office around noon</p>	G 143	<p>G143 Coordination of patient services <u>Person Responsible:</u> D.O.N. <u>Plan of Correction:</u> A new policy and procedure has been written to outline the chain of command for communicating incident/accidents. The policy also establishes agency parameters for vital signs, O2 sats and pain level, and when to notify the RN and/or MD of any significant change in the patients status. The reporting system will keep the RN and therapies in closer contact and will give the clients better care. <u>Date of Compliance:</u> June 10, 2014</p> <p>G143 Addendum All staff has been in serviced on chain of command For communicating and documenting accident/incidents. Also in serviced on agency parameters for vital signs, O2 sats and pain level, and when to notify RN and/or MD of any significant change in patients status. The policy and procedure has been reviewed with all staff, outlining details. We will perform 100% chart review until 80%compliant.</p>	

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G 143	<p>Continued From page 3 on 4/24/14 and 4/25/14.</p> <p>A "PHYSICAL THERAPY VISIT REPORT" dated 4/24/14, with a stamp "RECEIVED MAY 06 2014," included documentation Patient #14 tripped but no injury was noted. The visit note included a check mark by the printed "Communication with other disciplines: Nursing and PTA," but there was no indication of when the communication occurred or what it included.</p> <p>During an interview on 5/08/14 beginning at 3:00 PM, the DON and Administrator reviewed Patient #14's record and confirmed the documentation of his fall. The DON stated she admitted Patient #14 to the agency, and performed his SOC assessment. The DON stated she was not informed that he fell, and was surprised that the therapist noted he was unable to reach anyone at the office on 4/24/14 or 4/25/14. The Administrator stated when the office phone rang, it was routed to herself or her designee if there was no one in the office. Both the Administrator and DON stated they were unaware of Patient #14's fall, and an incident report should have been completed by the physical therapist. The Administrator confirmed the therapy note arrived at the office 12 days after the visit was conducted.</p> <p>The therapist did not ensure Patient #14's fall was communicated to the patient care team.</p> <p>2. Patient #8 was a 60 year old woman admitted to the agency on 1/27/14, for uncontrolled DM Type II. Additional diagnoses included an ulcer on her calf, HTN and manic depressive psychosis. Patient #8's records for the certifications periods of 1/27/14 to 3/27/14, and</p>	G 143			

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G 143	Continued From page 4 3/28/14 to 5/26/14 were reviewed. She received SN and PT services from the agency. Patient #8's record included a PTA visit note dated 4/18/14. The PTA documented her BP as 126/111. A PTA visit note dated 4/21/14, documented her BP as 151/128. Patient #8's record did not include documentation to indicate the physical therapist or RN were notified of her elevated BP readings. During an interview on 5/08/14 at 10:40 AM, the DON reviewed Patient #8's record and confirmed her Physical Therapist and RN were not notified of her elevated blood pressure readings. The agency failed to ensure care coordination between disciplines occurred.	G 143		
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on staff and patient interview, review of medical records and agency policies, and observation it was determined the agency failed to ensure POCs were completely developed, followed, and updated. These failures had the potential to result in unmet patient needs and negatively impact the continuity, safety, and quality of patient care. Findings include: 1. Refer to G158 as it relates to the failure of the agency to ensure care was provided in accordance with POCs.	G 156	G156 Acceptance of Patients, POC, Med Super <u>Person Responsible:</u> DON & QA RN <u>Plan of Correction:</u> A chart review and oasis review will be initiated with each patient. The staff will be in-serviced for documentation to POC, following MD orders, receiving verbal orders for initial POC, verbally notify MD of any changes to POC. Also in-service staff to pertinent DME that needs to be on 485. All 485 will include PT/DT orders and goals. policy and procedures to be written pertaining to documentation, verbal SOC orders, all visits to include vital signs, interventions need to be related to 485, notify MD of any changes in condition of the client and any change in the POC. With the improved communication between MD, therapist and skilled nursing quality of care will be significantly improved. Date of Correction: 6-10-2014 Refer to Exhibit 11, 12 Refer to: G156 G158: Failure to ensure care as ordered by MD G159: POC needs to include PT, OT orders and goals G160: Verbal SOC order r/t POC G164: Notifying MD of changes in patient condition Addendum to G156 The policy and procedure has been reviewed With all staff, outlining the details. 100% chart review will be performed Until 80% complaint.	

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G 156	Continued From page 5	G 156			
G 158	<p>2. Refer to G159 as it relates to the failure of the agency to ensure the POC included all pertinent diagnoses, types of services and equipment required.</p> <p>3. Refer to G160 as it relates to the failure of the agency to ensure a physician was contacted to approve changes or additions to the POC.</p> <p>4. Refer to G164 as it relates to the failure of the agency to notify the physician with changes in patients' conditions.</p> <p>The cumulative effect of these negative systemic practices impeded the agency in providing quality care in accordance with established POCs.</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure care followed a physician's written POC for 2 of 14 patients (#3 and #6) whose records were reviewed. This resulted in unauthorized treatments and visits, as well as, omissions of care and had the potential to result in negative patient outcomes. Findings include:</p> <p>1. Patient #3's record documented a 66 year female who was admitted to the agency on 9/26/13 for SN services related to a psychiatric</p>	G 158	<p>G158 & G156 Acceptance of Patients, POC, Med Super <u>Person Responsible:</u> DON & QA RN <u>Plan of Correction:</u> A chart review and oasis review will be initiated with each patient. The staff will be in-serviced for documentation to POC, following MD orders, receiving verbal orders for initial POC, verbally notify MD of any changes to POC. Also in-service staff to pertinent DME that needs to be on 485. All 485 will include PT/OT orders and goals. P&P to be written pertaining to documentation, verbal SOC orders, all visits to include vital signs, interventions need to be related to 485, notify MD of any changes in condition of the client and the additions or deletion's to the POC. With the updated communication between MD, Therapies and RN the services provided will be consistent to the POC and be better quality service. Date of Correction: 6-10-2014 Refer to Addendum 11, 12 Refer to: G158: Failure to ensure care as ordered by MD G159: POC needs to include PT, OT orders and goals G160: Verbal SOC order r/t POC G164: Notifying MD of changes in patient condition</p> <p>G 158 Addendum The policy and procedure has been reviewed With the nursing and therapy staff, outlining Details of POC and verbal SOC orders. Charts will be 100% reviewed until 80% Compliant.</p>		

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G 158	<p>Continued From page 6</p> <p>diagnosis of paranoid schizophrenia. Patient #3 required an Intramuscular Injection every other week.</p> <p>A recertification assessment was completed on 3/20/14. Vital signs were not documented on the assessment. Additionally, Patient #3's POC for the certification period 3/25/14 to 5/23/14 included interventions with each nursing visit. They included physical assessments, monitoring vital signs, instruction regarding depression, and assessment of psycho/social status each visit.</p> <p>Nursing visit notes during the current certification period of 3/25/14 to 5/23/14 did not include interventions related to Patient #3's diagnosis as follows:</p> <ul style="list-style-type: none"> - 3/27/14, "Pt [patient] awake, dressed, reports doing well. VS taken, assessment completed. Pt will call for any questions or concerns. No recent MD [medical doctor] appts [appointments] scheduled." - 4/10/14, "Pt awake, dressed, up in LR [living room]. VS taken, assessment completed. Pt states no recent MD appt. Taking meds as ordered." - 4/24/14, "Pt awake, dressed, up in LR. Pt groomed and clean. No upcoming appts. VS taken, assessment completed." <p>The visit notes did not include the interventions on the POC which related to assessment of Patient #3's psycho/social status, depression assessment, or medication compliance.</p> <p>During an interview on 5/08/14 beginning at 2:20</p>	G 158		
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G 158	<p>Continued From page 7</p> <p>PM, the DON reviewed Patient #3's record and confirmed the nursing notes did not include the interventions as the POC directed.</p> <p>Patient #3 was not provided the services as directed on her POC.</p> <p>2. Patient #6 was a 92 year old woman admitted to the agency on 3/05/14, for care of a stage II decubitus ulcer. Additional diagnoses included atrial fibrillation, macular degeneration and depression. Patient #6 received SN, PT and aide services from the agency.</p> <p>a. Patient #6's record included a fax dated 3/25/14, which documented Patient #6's coccyx wound care. The fax stated "SN to cleanse with NS, apply barrier cream then cover with border foam. 2-3x/wk and PRN..."</p> <p>Patient #6's record included a NURSING VISIT RECORD dated 4/11/14, containing the following documentation, "SN visit for dressing change. Pt [patient] has dressing on coccyx intact. Dressing left in place as it is a 7 day dressing and it has stayed on very well."</p> <p>During an interview on 5/08/14 at 11:10 AM, the DON and Administrator reviewed Patient #6's record and confirmed the physician's order for wound care was not followed.</p> <p>Patient #6's wound care was not provided as ordered by her physician.</p> <p>b. Patient #6's record included a "SUPPLEMENTAL PLAN OF TREATMENT" dated and signed by her physician on 3/16/14. It included orders for SN visits 3-4 times a week for</p>	G 158		

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G 158	Continued From page 8 1 week, and 2-3 times a week for 3 weeks. The 4 week period ended on 4/12/14. Patient #6's record also included a fax written on 5/01/14, and signed by her physician on 5/02/14. The fax included an order request for SN visits 1 time a week, effective 4/21/14. There was no indication a verbal order was obtained from her physician. Patient #6's record documented SN visits completed on 4/15/14, 4/18/14 and 4/22/14. Her record did not include physician's orders for the 3 visits. During an interview on 5/08/14 at 11:10 AM, the DON and Administrator reviewed Patient #6's record and confirmed the visits were completed without a physician's order. The agency failed to ensure care followed a physician's written POC.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on review of patient records, observation	G 159	G159 & G156 Acceptance of Patients, POC, Med Super <u>Person Responsible:</u> DON & QA RN <u>Plan of Correction:</u> A chart review and oasis review will be initiated with each patient. The staff will be in-serviced for documentation to POC, following MD orders, receiving verbal orders for initial POC, verbally notify MD of any changes to POC. Also in-service staff to pertinent DME that needs to be on 485. All 485 will include PT/OT orders and goals. P&P to be written pertaining to documentation, verbal SOC orders, all visits to include vital signs, interventions need to be related to 485, notify MD of any changes in condition of the client and the additions or deletion's to the POC. With the updated communication between MD, Therapies and RN the services provided will be consistent to the POC and be better quality service. Date of Correction: 6-10-2014 Refer to: Exhibit 12, 13, 14 Refer to: G158: Failure to ensure care as ordered by MD G159: POC needs to include PT, OT orders and goals G160: Verbal SOC order r/t POC G164: Notifying MD of changes in patient condition G159 Addendum The policy and procedure has been reviewed With the nursing and therapy staff, outlining Details. There will be 100% chart review Until 80% compliant.	

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NAME OF PROVIDER OR SUPPLIER HELPING HANDS HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1308 EAST CENTER POCATELLO, ID 83201		
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G 159	<p>Continued From page 9</p> <p>during home visits, patient and staff interview, it was determined the agency failed to ensure POCs included all pertinent information, including diagnoses and appropriate nursing interventions, treatments and equipment for 6 of 14 patients (#4, #5, #8, #10, #12 and #13) whose records were reviewed. This had the potential to interfere with the thoroughness and consistency of patient care. Findings include:</p> <p>1. Patient #8 was a 60 year old woman admitted to the agency on 1/27/14, for uncontrolled DM Type II. Additional diagnoses included an ulcer on her calf, HTN and manic depressive psychosis. Patient #8's records for the certification periods of 1/27/14 to 3/27/14, and 3/28/14 to 5/26/14, were reviewed.</p> <p>a. Patient #8's record included documentation completed by a physician during a hospitalization immediately prior to her admission to the agency. The documentation stated Patient #8 arrived at the hospital with a blood glucose level of 822 mg/dL. According to the National Institute of Health, a normal non-fasting blood sugar is less than 125 mg/dL.</p> <p>Additionally, the hospital documentation stated Patient #8 did not know how to use a glucometer (a medical device used to check blood sugars at home). Prior to her hospitalization, she had been taking scheduled doses of insulin in the morning and evening. She had never used sliding scale insulin dosing, which varied the dose of insulin based on the glucometer results.</p> <p>An inpatient progress note, completed by the hospital physician on 1/25/14, stated the physician had significant concerns regarding</p>	G 159			

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G 159	<p>Continued From page 10</p> <p>Patient #8's ability to manage her diabetes at home, related to her use of a glucometer and administration of insulin.</p> <p>Patient #8's POC signed by the physician on 4/02/14, included orders for blood glucose testing by glucometer before meals and at bedtime, and sliding scale insulin dosing based on her blood glucose levels. The POC included orders for SN treatments and interventions. However there were no specific orders related to an assessment of Patient #8's understanding of sliding scale insulin dosing or of her ability to use a glucometer correctly. Additionally, the POC did not include interventions to educate Patient #8 regarding the use of a glucometer or of sliding scale insulin dosing.</p> <p>During an interview on 5/08/14 at 10:40 AM, the DON reviewed Patient #8's record and confirmed her POC did not include interventions to educate her in the use of a glucometer and sliding scale insulin dosing.</p> <p>Patient #8's POC did not cover all types of services and treatments required for her care.</p> <p>b. Patient #8's POC, signed by the physician on 4/02/14, documented she was to receive oxygen 2 LPM continuously. Her POC did not include an oxygen concentrator, tanks or oxygen tubing.</p> <p>During an interview on 5/08/14 at 10:40 AM, the DON reviewed Patient #8's record, stated her oxygen was delivered by a concentrator and confirmed the POC did not include the oxygen concentrator as DME.</p> <p>Patient #8's POC did not include all DME.</p>	G 159			

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G 159	<p>Continued From page 11</p> <p>2. Patient #10 was a 75 year old woman admitted to the agency on 11/18/13, for care related to DM Type II and an ulcer on her foot. Additional diagnoses included CHF and chronic kidney disease.</p> <p>A home visit was made on 5/06/14, to observe an OT visit. During the visit, Patient #10 was noted to have an oxygen concentrator. She stated she had been using it for several months.</p> <p>However, Patient #10's record for the certification period 3/18/14 to 5/16/14 was reviewed. Patient #10's POC did not include an oxygen concentrator or oxygen supplies.</p> <p>During an interview on 5/08/14 at 11:45 AM, the DON reviewed Patient #10's record and confirmed her POC did not include an oxygen concentrator or supplies.</p> <p>Patient #10's POC did not include all DME.</p> <p>3. Patient #5 was a 93 year old woman admitted to the agency on 2/13/14, for care related to difficulty in walking. Additional diagnoses included atrial fibrillation, HTN and depression.</p> <p>Patient #5's record for the certification period of 4/14/14 to 6/12/14 was reviewed. Her POC signed by her physician on 4/29/14, documented she was to receive oxygen 3 LPM continuously. However, her POC did not include an oxygen concentrator or tanks.</p> <p>During an interview on 5/08/14 at 10:40 AM, the DON reviewed Patient #5's record, stated her oxygen was delivered by a concentrator and</p>	G 159		

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G 159	<p>Continued From page 12</p> <p>confirmed her POC did not include an oxygen concentrator as DME.</p> <p>Patient #5's POC did not include all DME.</p> <p>4. Patient #13 was a 97 year old woman admitted to the agency on 3/12/14, after discharge from a rehabilitation center for care related to a fractured pelvis. Additional diagnoses included HTN, anxiety and history of a stroke.</p> <p>A PT note, dated 3/17/14, documented the use of a pedaler and a single point cane. However, her POC, signed by the RN on 3/12/14, did not include a pedaler or single point cane.</p> <p>During an interview on 5/8/14 at 10:30 AM, the DON reviewed Patient #13's record and confirmed her POC did not include a pedaler or single point cane as DME.</p> <p>Patient #13's POC did not include all DME.</p> <p>5. Patient #4's record documented an 83 year old male who was admitted to the agency on 4/13/14, for SN and PT services related to venous insufficiency, difficulty walking, type II DM, an irregular heartbeat, and HTN.</p> <p>Patient #4's SOC assessment dated 4/13/14, noted Patient #4 used oxygen during the night. Under locator #16, "Safety Measures," oxygen precautions were included, however the oxygen concentrator and oxygen tubing was not included as DME. Additionally, Patient #4's POC for the certification period 4/13/14 to 6/11/14, did not include oxygen equipment as DME and medications listed on the POC did not include oxygen.</p>	G 159			

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G 159	<p>Continued From page 13</p> <p>During an interview on 5/08/14 at 2:05 PM, the DON and Administrator reviewed Patient #4's record and confirmed oxygen and the oxygen related equipment was not included on his POC.</p> <p>Patient #4's POC was incomplete and did not include all medications and DME.</p> <p>6. Patient #12's record documented a 71 year old female who was admitted to the agency on 12/17/13 for SN, aide and PT services related to Lupus (an auto immune disease), CHF, HTN, Type II DM, and abnormal gait.</p> <p>Patient #12's POC for the certification period 4/16/14 to 6/14/14 was reviewed. During a home visit on 5/07/14 beginning at 11:00 AM, the following DME were identified that were not included on the POC:</p> <ul style="list-style-type: none"> - An oxygen concentrator, - 2 "E" portable oxygen tanks, - a nebulizer to deliver breathing treatments, - a "reacher" device to pick up small items, - a wheelchair. <p>During an interview on 5/08/14 beginning at 2:24 PM, the DON and Administrator reviewed Patient #12's record and confirmed the respiratory supplies and assistive devices she used in her home were not included on the POC.</p> <p>Patient #12's POC was incomplete and did not include all DME.</p> <p>The agency failed to ensure POCs included all pertinent information.</p>	G 159		

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G 160 G 160	Continued From page 14 484.18(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 staff interview, it was determined the agency failed to ensure a physician was consulted to approve changes or additions to the plan of care for 9 of 14 patients (#1, #4, #5, #6, #8, #11, #12, #13 and #14) whose records were reviewed. This resulted in POCs that were developed without therapy input and physician approval. Findings include: 1. During the entrance interview with the Administrator and DON on 5/05/14 beginning at 2:00 PM, the DON described the process for developing the POC for each patient. The DON stated it was the practice of the agency that all assessments would be performed by an RN. She stated that after the SOC assessment, the nurse would submit to the physician a written summary. She stated the summary included a space for the physician to sign, and the agency considered the signed form "verbal orders" for the POC. The DON stated physicians were not contacted by phone unless there was an immediate problem that would need to be addressed. Patient #14's medical record documented an 81 year old male who was admitted to the agency on 4/03/14, for SN and therapy services related to imbalance, weakness, Type II DM, and HTN. The physician referral was dated 4/01/14, for nursing and therapy services.	G 160 G 160	G160 Acceptance of Patients, POC, Med Super <u>Person Responsible:</u> DON & QA RN <u>Plan of Correction:</u> A chart review and oasis review will be initiated with each patient. The staff will be in-serviced for documentation to POC, following MD orders, receiving verbal orders for initial POC, verbally notify MD of any changes to POC. Also in-service staff to pertinent DME that needs to be on 485. All 485 will include PT/OT orders and goals. policy and procedures to be written pertaining to documentation, verbal SOC orders, all visits to include vital signs, interventions need to be related to 485, notify MD of any changes in condition of the client and any change in the POC. With the improved communication between MD, therapist and skilled nursing quality of care will be significantly improved. Date of Correction: 6-10-2014 Refer to: Exhibit 9, 10, 11, 12 Refer to: G158: Failure to ensure care as ordered by MD G159: POC needs to include PT, OT orders and goals G160: Verbal SOC order r/t POC G164: Notifying MD of changes in patient condition G160 Addendum The policy and procedure has been reviewed With the nursing and therapy staff, outlining Details. The charts will be reviewed 100% until they are 80% complaint		

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G 160	Continued From page 15 Patient #14's POC for the certification period 4/03/14 to 6/01/14, documented it was sent to the physician for approval 4/08/14, which was 5 days after his SOC. As of 5/08/14, the POC was not signed by Patient #14's physician. Additionally, the record did not indicate his physician was consulted for orders before initiation of the POC and the initiation of services. During an interview on 5/08/14 at 3:00 PM, the DON and Administrator reviewed Patient #14's record and confirmed the physician had not been contacted after the SOC assessment. Patient #14's POC was not established by a physician prior to the SOC.	G 160		
G 164	2. Refer to G186 as it relates to the failure of the agency to ensure therapists assisted the physician and nurse in the development and revisions of the plan of care. 484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on review of clinical records and staff interview, 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 14 patients (#3, #8 and #14) whose records were reviewed. This resulted in missed opportunity for	G 164	G164 Acceptance of Patients, POC, Med Super <u>Person Responsible:</u> DON & QA RN <u>Plan of Correction:</u> A chart review and oasis review will be initiated with each patient. The staff will be in-serviced for documentation to POC, following MD orders, receiving verbal orders for initial POC, verbally notify MD of any changes to POC. Also in-service staff to pertinent DME that needs to be on 485. All 485 will include PT/OT orders and goals. P&P to be written pertaining to documentation, verbal SOC orders, all visits to include vital signs, interventions need to be related to 485, notify MD of any changes in condition of the client and the additions or deletion's to the POC. With the updated communication between MD, Therapies and RN the services provided will be consistent to the POC and be better quality service. Date of Correction: 6-10-2014 Refer to: Exhibit 9, 10, 11, 12, 13, 14 Refer to: G158: Failure to ensure care as ordered by MD G159: POC needs to include PT, OT orders and goals G160: Verbal SOC order r/t POC G164: Notifying MD of changes in patient condition G164 Addendum The policy and procedure has been reviewed With the nursing and therapy staff, outlining Details. There will be 100% chart review Until 80% compliant.	

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G 164	<p>Continued From page 16</p> <p>the physician to alter the POC to meet patient needs. Findings include:</p> <p>1. Patient #8 was a 60 year old woman admitted to the agency on 1/27/14, for uncontrolled DM Type II. Additional diagnoses included an ulcer on her calf, HTN and manic depressive psychosis. Patient #8's records for the certifications periods of 1/27/14 to 3/27/14, and 3/28/14 to 5/26/14 were reviewed. She received SN and PT services from the agency.</p> <p>Patient #8's POC for the certification period of 3/28/14 to 5/26/14, signed by her physician on 4/02/14, included orders to notify her physician of systolic BP greater than 180 or less than 100, and diastolic BP greater than 90 or less than 50. A PTA visit note dated 4/18/14, documented Patient #8's BP as 126/111. APTA visit note dated 4/21/14, documented her BP as 151/128.</p> <p>Patient #8's record did not include documentation to indicate the physical therapist, RN or physician were notified of her elevated BP readings.</p> <p>During an interview on 5/08/14 at 10:40 AM, the DON reviewed Patient #8's record and confirmed her physician was not notified of her blood pressure readings as directed on her POC.</p> <p>2. Patient #3's record documented a 66 year female who was admitted to the agency on 9/26/13 for SN services related to a psychiatric diagnosis of paranoid schizophrenia. Patient #3 required an intramuscular injection every other week.</p> <p>A recertification assessment was performed on 3/20/14, and did not include vital signs. The POC</p>	G 164			

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G 164	<p>Continued From page 17</p> <p>for the certification period 3/25/14 to 5/23/14 did not include parameters with which to notify the physician if vital signs were out of acceptable range.</p> <p>In a nursing visit record dated 4/10/14, the RN noted Patient #3's blood pressure was 98/60. The nurse did not document if the blood pressure was repeated, or if the physician was notified.</p> <p>During an interview on 5/08/14 beginning at 2:20 PM, the DON reviewed Patient #3's record and confirmed the POC did not include parameters when the physician would be notified for abnormal findings during an assessment.</p> <p>The agency did not report Patient #3's abnormal blood pressure to her physician.</p> <p>3. Patient #14 was an 81 year old male who was admitted to the agency on 4/03/14 for PT and SN services related to imbalance, weakness, Type II DM, and HTN.</p> <p>Patient #14's record included a typed note, dated 4/25/14, that was signed by Staff S, a physical therapist. The note included a stamp "RECEIVED APR 28 2014" and included documentation that Patient #14 tripped over a step stool in his kitchen. The document noted Patient #14 suffered abrasions to his nose and forehead. Additionally, Staff S noted he had attempted to contact the HHA office around noon on 4/24/14 and 4/25/14.</p> <p>A "PHYSICAL THERAPY VISIT REPORT" dated 4/24/14, with a stamp "RECEIVED MAY 06 2014," included documentation Patient #14 tripped but no injury was noted. The visit note included a</p>	G 164			

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G 164	Continued From page 18 check mark by the printed "Communication with other disciplines: Nursing and PTA," but there was no indication of when the communication occurred or what it included. The document did not indicate Patient #14's physician was notified of his fall or resulting injuries. During an interview on 5/08/14 at 3:00 PM, the DON and Administrator reviewed Patient #14's record and confirmed the documentation of his fall. Both the Administrator and DON stated they were unaware of Patient #14's fall, and his physician should have been notified by the physical therapist or case manager. The Administrator confirmed the therapy note informing the office of Patient #14's fall arrived at the office 12 days after the visit was conducted.	G 164		
G 186	Patient #14's physician was not notified of his fall. 484.32 THERAPY SERVICES The qualified therapist assists the physician in evaluating the patient's level of function, and helps develop the plan of care (revising it as necessary.) This STANDARD is not met as evidenced by: Based on policy review, record review, and staff interview it was determined the agency failed to ensure therapists assisted the physician in developing the plan of care for 9 of 11 patients (#1, #4, #5, #6, #8, #11, #12, #13 and #14) who received therapy services and whose records were reviewed. This had the potential for patients to receive therapy services without physician input or physician awareness of the services being provided.	G 186	G186 Therapy Services <u>Persons Responsible:</u> Administrator, D.O.N. <u>Plan of Correction:</u> The therapists will be in serviced regarding the Verbal SOC, recert, resumptions, or change of care orders. They will also be in serviced to notify the case manager of the POC. PT and OT orders, interventions, and goals will be included on the 485. A policy and procedure has been implemented regarding therapist responsibilities. The therapists have been in serviced regarding this policy. With improved communication between the MD, therapists, and skilled nursing the quality Of client care will be significantly improved. Date of Compliance: June 10, 2014 Refer to Exhibit: 9, 12, 15, 16 G186 Addendum The policy and procedure has been reviewed With the therapy staff, outlining details. Charts will be monitored 100% until 80% Compliant.	

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NAME OF PROVIDER OR SUPPLIER HELPING HANDS HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1308 EAST CENTER POCATELLO, ID 83201	
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G 186	<p>Continued From page 19</p> <p>1. The Occupational Therapist was interviewed on 5/06/14 at 3:00 PM. He stated he did not contact the physician after completing his evaluations unless he had a specific question or concern. He stated he submitted his evaluation to the agency office and it was then faxed to the physician for signature. He also stated he was not notified when the physician signed evaluation was received by the agency.</p> <p>Additionally, during the entrance interview with the Administrator and DON on 5/05/14 beginning at 2:00 PM, the DON described the process for developing the POC for each patient. The DON stated it was the practice of the agency that all assessments would be performed by an RN. She stated that after the SOC assessment, the nurse would submit to the physician a written summary. She stated the summary included a space for the physician to sign, and the agency considered the signed form "verbal orders" for the POC. The DON stated physicians were not contacted by phone unless there was an immediate problem that would need to be addressed. Additionally, the DON stated the therapy orders on the POC included only an evaluation order. She stated further orders would be provided after the evaluation was completed by the therapist, and would be sent to the physician to be signed.</p> <p>However, patient records did not include physician approval for therapy services prior to care being provided as follows:</p> <p>a. Patient #4's record documented an 83 year old male who was admitted to the agency on 4/13/14 for SN and PT services related to venous insufficiency, difficulty walking, type II DM, an</p>	G 186		

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G 186	<p>Continued From page 20 Irregular heartbeat, and HTN.</p> <p>A therapy evaluation was dated 4/14/14, and included a section "PHYSICAL THERAPY ORDERS." The orders included activities and frequency of therapy visits. The evaluation did not include evidence Patient #4's physician was contacted for the orders. The evaluation was not signed by Patient #4's physician.</p> <p>Patient #4 received one additional therapy visit on 4/15/14, and was discharged on 5/06/14.</p> <p>During an interview on 5/08/14 at 2:05 PM, the DON and Administrator reviewed Patient #4's record and confirmed the therapist had not documented speaking with a physician to obtain orders and confirmed his physician had not been contacted for further development of the POC.</p> <p>Patient #4 received therapy services without physician approval to the POC and Patient #4's physician was not consulted by the therapist for changes to the POC.</p> <p>b. Patient #12's record documented a 71 year old female who was admitted to the agency on 12/17/13, for SN, aide and PT services related to Lupus (an auto immune disease), CHF, HTN, Type II DM, and abnormal gait.</p> <p>A recertification assessment was performed on 4/15/14. The POC for the certification period 4/16/14 to 6/14/14, was signed by Patient #12's physician, and included PT frequency, however the PT activities and goals were not specified.</p> <p>A PT Reevaluation was performed on 4/16/14, and included a section "PHYSICAL THERAPY</p>	G 186			

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G 186	<p>Continued From page 21</p> <p>ORDERS." The orders included activities and frequency of therapy visits. The evaluation was not signed by Patient #12's physician, and did not include documentation the physician had been contacted to obtain orders.</p> <p>Patient #12's record documented PT visits on 4/22/14, 4/24/14, 4/29/14, and 5/01/14.</p> <p>During an interview on 5/08/14 at 2:24 PM, the DON and Administrator reviewed Patient #12's record and confirmed the therapist had not documented speaking with a physician to obtain orders.</p> <p>Patient #12 received therapy services without physician approval.</p> <p>c. Patient #14's medical record documented an 81 year old male who was admitted to the agency on 4/03/14, for SN and therapy services related to imbalance, weakness, Type II DM, and HTN. The physician referral was dated 4/01/14, for nursing and therapy services.</p> <p>A PT evaluation was completed on 4/04/14 at 2:30 PM. The evaluation did not include documentation Patient #14's physician was contacted to secure orders for further therapy visits. The evaluation was noted to be faxed to Patient #14's physician on 4/15/14.</p> <p>Physical therapy services were provided on 4/10/14, 4/17/14, 4/24/14 and 4/29/14.</p> <p>During an interview on 5/08/14 at 3:00 PM, the DON and Administrator reviewed Patient #14's record and confirmed the physician had not been contacted and confirmed 4 therapy visits after the</p>	G 186			

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G 186	<p>Continued From page 22</p> <p>evaluation were performed without physician orders.</p> <p>Patient #14's POC was not established by a physician prior to the therapist performing services.</p> <p>d. Patient #1 was a 63 year old woman admitted to the agency on 7/27/13, following a hospitalization for CHF. Additional diagnoses included uncontrolled DM Type II, atrial fibrillation and pulmonary hypertension. Patient #1's record for the certification period of 9/25/13 to 11/23/13 was reviewed. She received SN, PT, MSW and aide services during the certification period.</p> <p>Patient #1's record included an OT evaluation form dated 10/1/13. Her record did not indicate her physician was contacted after the evaluation to develop the POC. OT visits were performed on 10/04/13, 10/08/13 and 10/10/13, before the agency received signed physician orders by fax, dated 10/11/13.</p> <p>Patient #1's record also included a PT evaluation form dated 10/2/13. Her record did not indicate her physician was contacted after the evaluation to develop the POC. PT visits were performed on 10/04/13, 10/07/13, 10/08/13, 10/10/13, 10/15/13 and 10/17/13, before the agency received signed physician orders by fax, dated 11/01/13.</p> <p>During an interview on 5/08/14 at 11:40 AM, the DON and Administrator reviewed Patient #1's record and confirmed her physician had not been contacted by the physical or occupational therapist after the evaluations to establish the POC. The DON confirmed 3 OT visits and 6 PT visits were performed prior to contact with the</p>	G 186		

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G 186	<p>Continued From page 23 physician.</p> <p>Patient #1's POC for PT and OT was not established by a physician prior to the therapists performing services for the patient.</p> <p>e. Patient #5 was a 93 year old woman admitted to the agency on 2/13/14, for care related to difficulty in walking. Additional diagnoses included atrial fibrillation, HTN and depression. Patient #5's record for the certification period of 4/14/14 to 6/12/14 was reviewed. She received SN and PT services during the certification period.</p> <p>Patient #5's record included a PT evaluation form dated 4/14/14. Her record did not indicate her physician was contacted after the evaluation to develop the POC. PT visits were performed on 4/16/14, 4/21/14, 4/23/14 and 4/28/14, before the agency received signed physician orders by fax, dated 4/29/14.</p> <p>During an interview on 5/08/14 at 11:00 AM, the DON and Administrator reviewed Patient #5's record and confirmed her physician had not been contacted by the physical therapist after the PT evaluation on 4/14/14, to establish the POC. The DON confirmed 4 PT visits were performed prior to contact with the physician.</p> <p>Patient #5's POC for PT was not established by a physician prior to the physical therapist performing services for the patient.</p> <p>f. Patient #6 was a 92 year old woman admitted to the agency on 3/05/14, for care of a stage II decubitus ulcer. Additional diagnoses included atrial fibrillation, macular degeneration and</p>	G 186		

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G 186	<p>Continued From page 24</p> <p>depression. Patient #6 received SN, PT and aide services from the agency.</p> <p>Patient #6's record included a PT evaluation form dated 3/07/14. Her record did not indicate her physician was contacted after the evaluation to develop the POC. PT visits were performed on 3/10/14, 3/17/14, 3/19/14, 3/21/14, 3/24/14 and 3/26/14, before the agency received signed physician orders by fax, dated 3/31/14.</p> <p>During an interview on 5/08/14 at 11:10 AM, the DON and Administrator reviewed Patient #6's record and confirmed her physician had not been contacted to establish the POC for the certification period after the PT evaluation on 3/07/14. The DON confirmed 6 PT visits were performed prior to contact with the physician.</p> <p>Patient #6's POC for PT was not established by her physician prior to the physical therapist performing services for the patient.</p> <p>g. Patient #8 was a 60 year old woman admitted to the agency on 1/27/14, for uncontrolled DM Type II. Additional diagnoses included an ulcer on her calf, HTN and manic depressive psychosis. Patient #8's records for the certification periods of 1/27/14 to 3/27/14, and 3/28/14 to 5/26/14 were reviewed. She received SN and PT services from the agency.</p> <p>Patient #8's record included a PT evaluation form dated 4/16/14. Her record did not indicate her physician was contacted after the evaluation to develop the POC. PT visits were performed on 4/17/14, 4/18/14, 4/21/14, 4/23/14, 4/25/14 and 4/28/14. As of 5/08/14, Patient #8's record did not document contact with the physician related</p>	G 186			

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G 186	<p>Continued From page 25 to PT services.</p> <p>During an interview on 5/08/14 at 10:40 AM, the DON and Administrator reviewed Patient #8's record and confirmed her physician had not been contacted to establish the POC after the PT evaluation on 4/16/14. The DON confirmed 6 PT visits were performed without consultation with the physician.</p> <p>Patient #8's POC for PT was not established by a physician prior to the physical therapist performing services for the patient.</p> <p>h. Patient #11 was an 81 year old woman admitted to the agency on 1/06/14, following a hospitalization for surgical repair of her left hip fracture. Additional diagnoses included HTN and depression. Patient #11's record for the certification period 3/07/14 to 5/05/14 was reviewed. She received SN, PT and aide services during the certification period.</p> <p>Patient #11's record did not contain a PT evaluation form. There was no indication her physician was consulted to develop her PT POC for the certification period.</p> <p>PT visits were performed on 3/07/14, 3/08/14, 3/10/14, 3/12/14, 3/14/14, 3/17/14, 3/19/14, 3/21/14, 3/24/14, 3/26/14, 3/28/14, 3/31/14, 4/02/14, 4/04/14, 4/07/14, 4/09/14, 4/11/14, 4/14/14, 4/22/14, 4/23/14, 4/25/14, 4/28/14, 4/30/14, 5/02/14, and 5/05/14.</p> <p>Patient #11's record included documentation indicating she was hospitalized on 4/15/14 and resumed her home health services on 4/22/14. Her record contained a fax written by an RN on</p>	G 186		

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G 186	<p>Continued From page 26</p> <p>4/23/14, and signed by her physician. The physician's signature was not dated. The fax contained an order for PT visits to continue. The fax did not contain orders for PT treatments or goals related to PT. Further, Patient #11's record did not contain documentation of communication between her physician and the physical therapist during the certification period of 3/07/14 to 5/05/14.</p> <p>During an interview on 5/08/14 at 11:25 AM, the DON and Administrator reviewed Patient #11's record and confirmed her physician was not contacted by the physical therapist to establish the POC at the beginning of the certification period or following her hospitalization. The DON confirmed PT visits were performed without physician orders.</p> <p>Patient #11's PT POC was not established or reviewed by her physician.</p> <p>i. Patient #13 was a 97 year old woman admitted to the agency on 3/12/14, after discharge from a rehabilitation center for care related to a fractured pelvis. Additional diagnoses included HTN, anxiety and history of a stroke. Patient #13 received SN, PT and OT services from the agency.</p> <p>Patient #13's record included a PT evaluation form dated 3/14/14. Her record did not indicate her physician was contacted after the evaluation to develop the POC. PT visits were performed on 3/17/14, 3/21/14, 3/24/14, 3/27/14 and 3/31/14, before the agency received signed physician orders by fax, dated 4/03/14.</p> <p>Patient #13's record included an OT evaluation</p>	G 186		

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G 186	<p>Continued From page 27</p> <p>form dated 3/14/14. Her record did not indicate her physician was contacted after the evaluation to develop the POC. Her record included an OT visit note dated 3/17/14, before the agency received signed physician orders by fax, dated 3/19/14.</p> <p>During an interview on 5/08/14 at 10:30 AM, the DON and Administrator reviewed Patient #13's record and confirmed her physician had not been contacted by the physical or occupational therapist after the assessment to establish the POC. The DON confirmed 5 PT visits and 1 OT visit were performed without consultation with the physician.</p> <p>Patient #13's POC for PT and OT was not established by a physician prior to the therapists performing services for the patient.</p> <p>The agency failed to ensure therapists assisted the physician in developing patients' plans of care.</p>	G 186	<p>G202: Home Health Aide Services Person Responsible: DON An in service was provided to the nurses to give the home health aide a verbal report at SOC, and provide detailed written instruction (including DME) on the aide POC. In-services for the C.N.A's to complete 12 hours of training yearly. A copy of the aide POC will be maintained in the clients home folder. A joint visit will be made between the nurse and aide within 7 days of SOC. Aides will be in serviced to keep a copy of care plan with the, provide care according to the POC, and document to the POC. A copy of the aide POC will be maintained in each certification period of the clients chart. Improved written and verbal communication between the SN and aide will improve client quality of care. <u>Date of Compliance:</u> June 10, 2014</p>	
G 202	<p>484.36 HOME HEALTH AIDE SERVICES</p> <p>This CONDITION is not met as evidenced by: Based on record review, personnel record review, review of the in-service training log, and staff interview it was determined the agency failed to ensure annual evaluations were performed, initial competency requirements were observed, and at least 12 hours of in-service training were provided annually for home health aides. In addition, the agency failed to ensure a written aide plan of care was provided. This had the potential to result in inadequate home health aide</p>	G 202	<p>Refer to: Exhibit: 1,2,3,4,5,6,7,8</p> <p>G202 Addendum The office staff (employee #1) will take the initial information from the new employee or contracted therapist. Employee #1 will create a file for the new employee/contractor. She will also log on a tracking record information regarding, licenses, continuing education, CPR, competency & performance evaluations, security clearance, other ongoing information related to work requirements. Employee #2 will follow up monthly to verify all records are still current. Employee #3 will do a quarterly monitoring of the records to ensure that all records will be current.</p>	

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G 202	Continued From page 28 care being provided. Findings include: 1. Refer to G212 as it relates to the failure of the agency to perform initial competency assessments for home health aides. 2. Refer to G213 as it relates to the failure of the agency to ensure the home health aides completed 12 hours of in-services each year and were evaluated for yearly competency. 3. Refer to G214 as it relates to the failure of the agency to provide annual performance review of competencies for home health aides. 4. Refer to G215 as it relates to the failure of the agency to ensure home health aides received a minimum of 12 hours of in-service training annually. 5. Refer to G224 as it relates to the failure of the agency to ensure the RN provided written instructions for the home health aide. The cumulative effect of these negative systemic practices had the potential to negatively impact patient care.	G 202	G212 Competency Evaluation <u>Person Responsible:</u> Administrator <u>Plan of Correction:</u> The HHA Format has been changed to restructure the process from hiring (HHA Supplemental checklist) to yearly Competence and Performance evaluations, In-Service/Education P&P have been revised to cover the added instructions. <u>Description of improvement:</u> Competency and Performance evaluations, In-services/Education have been revised to coordinate the new employees duties, education and training. Administrator and DON have in-serviced the RN staff of the importance of training, continued education and monitoring of the HHA. DON, office manager, admin will monitor the records and new hires to ensure the training and records are kept current for more efficient care. <u>Date of Correction:</u> 06-10-2014 Refer to Exhibit: 1,2,3,4,5,6,7,8	
G 212	484.36(b)(1) COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section. This STANDARD is not met as evidenced by: Based on review of personnel records and staff	G 212	G212 Addendum The office staff (employee #1) will take the initial information from the new employee or contracted therapist. Employee #1 will create a file for the new employee/contractor. She will also log on a tracking record information regarding, licenses, continuing education, CPR, competency & performance evaluations, security clearance, other ongoing information related to work requirements. Employee #2 will follow up monthly to verify all records are still current. Employee #3 will do a quarterly monitoring of the records to ensure that all records will be current. The policy and procedures have been reviewed with The home health aide staff, outlining details Charts will be monitored 100% until 80 % compliant	

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G 212	<p>Continued From page 29</p> <p>interview, it was determined the agency failed to ensure 7 of 11 home health aides (Staff C, E, G, H, I, J, and K), whose records were reviewed, met skill and competency evaluation requirements. This had the potential to allow home health aides who had not met competency requirements to provide services on behalf of the agency. Findings include:</p> <p>1. Personnel records were reviewed with the DON and Administrator on 5/08/14 at 11:55 AM and included review of the following home health aides:</p> <ul style="list-style-type: none"> - Aide C, date of hire 4/02/08. - Aide I, date of hire 9/01/99. - Aide E, date of hire 8/23/12. <p>Competency evaluations and skills checklists could not be found for the above listed aides. Additionally, the personnel records of Aides G, H, J, and K included the following:</p> <ul style="list-style-type: none"> - Aide G, date of hire 3/24/14, skills checklist and competency evaluation, dated 5/06/14. - Aide H, date of hire 1/04/11, skills checklist and competency evaluation, dated 5/06/14. - Aide J, date of hire 8/20/08, skills checklist and competency evaluation, dated 5/05/14. - Aide K, date of hire 8/30/13, skills checklist and competency evaluation, dated 5/06/14. <p>During an interview on 5/08/14 at 11:55 AM, the DON, confirmed the personnel records were not</p>	G 212		
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G 212	Continued From page 30 current with accurate documentation of skills checklists and competency evaluations. She stated after the recertification survey started on 5/05/14 she reviewed home health aide files and started to complete the competency evaluations that were missing. She stated the forms she completed on 5/05/14 and 5/06/14 were not completed in the patient home and were not with the home health aide present, she was just attempting to update their files. She further stated home health aide annual evaluations had not been completed since 2011.	G 212			
G 213	The agency did not ensure home health aide records were maintained. 484.36(b)(2)(i) COMPETENCY EVALUATION & IN-SERVICE TRAI The competency evaluation must address each of the subjects listed in paragraphs (a)(1)(ii) through (xiii) of this section. This STANDARD is not met as evidenced by: Based on review of personnel records and staff interview, it was determined the agency failed to ensure the home health aides completed 12 hours of in-service training each year and that yearly evaluations were conducted for 11 of 11 home health aides (Staff A - K) whose records were reviewed. This had the potential to result in home health aides being inadequately trained and lacking the competencies necessary to perform their duties. The findings include: 1. Refer to G214 as it relates to the agency's failure to ensure yearly evaluations were	G 213	G213 <u>Person Responsible:</u> Administrator <u>Plan of Correction:</u> The HHA format has been changed to Restructure the process for hiring (HHA supplemental checklist) to Yearly Competence and Performance Evaluations, in -service/education P&P have been revised to cover the added instructions. <u>Description of improvement:</u> Competency and Performance evaluations, In-services/education have been revised to Coordinate the new employee duties, education and training. Administrator and DDN have in-serviced the RN staff of the importance of training, continued education and monitoring of the HHA, DON, office manager, Admin will monitor the records and new hires to ensure the training and records are kept current for more effective care. Date of Corrections: 06-10-2014 Refer to Exhibit: 1,2,3,4,5,6,7,8 G 213 Addendum The policy and procedure has been reviewed With the home health aide staff, outlining Details. Charts will be monitored 100% Until there is 80% compliance.		

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G 213	Continued From page 31 conducted for home health aides.	G 213			
G 214	<p>2. Refer to G215 as it relates to the agency's failure to ensure home health aides employed by the agency for more than one year, received a minimum of 12 hours of continuing education during the last twelve months of their employment.</p> <p>484.36(b)(2)(ii) COMPETENCY EVALUATION & IN-SERVICE TRAINING</p> <p>The HHA must complete a performance review of each home health aide no less frequently than every 12 months.</p> <p>This STANDARD is not met as evidenced by: Based on personnel record review and staff interview, it was determined the facility failed to ensure yearly evaluations were conducted for 9 of 9 home health aides (Staff A - F and H - J) who had been employed for more than one year. This had the potential to negatively impact quality and safety of patient care. Findings include:</p> <p>1. Personnel files were reviewed with the DON and Administrator on 5/08/14 at 11:55 AM. The aide personnel files did not include annual performance reviews, as follows:</p> <ul style="list-style-type: none"> - Aide A, hired 8/04/08. - Aide B, hired 3/11/98. - Aide C, hired 4/02/08. - Aide D, hired 5/14/08. 	G 214	<p>G214</p> <p><u>Person Responsible:</u> Administrator</p> <p><u>Plan of Correction:</u> The HHA format has been changed to Restructure the process for hiring (HHA supplemental checklist) to Yearly Competence and Performance Evaluations, in-service/education P&P have been revised to cover the added instructions.</p> <p><u>Description of Improvement:</u> Competency and Performance evaluations, In-services/education have been revised to Coordinate the new employee duties, education and training. Administrator and DON have in-serviced the RN staff of the importance of training, continued education and monitoring of the HHA, DON, office manager, Admin will monitor the records and new hires to ensure the training and records are kept current for more effective care. Date of Corrections: 06-10-2014 Refer to Exhibit: 1,2,3,4,5,6,7,8</p> <p>G214 Addendum The policy and procedure has been reviewed With the home health aide staff, outlining Details. Charts will be monitored 100% Until there is 80% compliance</p>		

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G 214	Continued From page 32 - Aide E, hired 8/23/12. - Aide F, hired 7/05/10. - Aide H, hired 1/04/11. - Aide I, hired 9/01/99. - Aide J, hired 8/20/08. In an interview on 5/08/14 at 11:55 AM, the DON confirmed annual performance reviews had not been completed for the aides. She further stated aide annual evaluations had not been completed since 2011.	G 214			
G 215	The agency failed to complete annual performance reviews for each home health aide. 484.36(b)(2)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAINING The home health aide must receive at least 12 hours of in-service training during each 12 month period. The in-service training may be furnished while the aide is furnishing care to the patient. This STANDARD is not met as evidenced by: Based on personnel record review, in-service training log review and staff interview, it was determined the facility failed to ensure 4 of 9 home health aides (A, B, C, and G) employed by the agency for more than one year, received a minimum of 12 hours of continuing education during the last twelve months of their employment. Failure to ensure home health aides were given opportunity for continued learning had the potential to lead to inappropriate	G 215	G215 <u>Person Responsible:</u> Administrator <u>Plan of Correction:</u> The HHA format has been changed to Restructure the process for hiring (HHA supplemental checklist) to Yearly Competence and Performance Evaluations, in-service/education P&P have been revised to cover the added instructions. <u>Description of improvement:</u> Competency and Performance evaluations, In-services/education have been revised to Coordinate the new employee duties, education and training. Administrator and DON have in-serviced the RN staff of the importance of training, continued education and monitoring of the HHA, DDN, office manager, Admin will monitor the records and new hires to ensure the training and records are kept current for more effective care. Date of Corrections: 06-10-2014 Refer to Exhibit: 1,2,3,4,5,6,7,8 G215 Addendum The policy and procedure has been reviewed With the home health aide staff, outlining Details. Charts will be monitored 100% Until there is 80% compliance		

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G 215	Continued From page 33 patient care. Findings include: 1. Personnel files were reviewed with the DON and Administrator on 5/08/14 at 11:55 AM. The aide personnel files included in-services records and contained test results of independent study topics the staff had taken throughout the year. However, the test results did not contain dates and were not scored to indicate the answers were correct or incorrect as follows: a. Records for Aide A, hired 8/04/08, included 8 undated test answer sheets from in-services. b. Records for Aide B, hired 3/11/98, included 10 undated test answer sheets from in-services. c. Records for Aide C, hired 4/02/08, included 3 undated test answer sheets from in-services. d. Records for Aide G, hired 5/14/08, included 2 undated test answer sheets from in-services. During an interview on 5/08/14 beginning at 11:55 AM, the DON reviewed the in-service records and confirmed the tests were not scored and were undated. The DON confirmed she was aware of the requirement for aides to have 12 in-service hours for the year. The facility failed to ensure that aides received a minimum of 12 hours of continuing education annually.	G 215			
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered	G 224			

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G 224	<p>Continued From page 34</p> <p>nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on record review, patient and staff interview, it was determined the agency failed to ensure the RNs prepared accurate and current written patient care instructions for the home health aides of 2 of 8 patients (#9 and #11) who were receiving aide services and whose records were reviewed. This resulted in aides providing services not included on the plan of care. Findings include:</p> <p>1. Patient #9 was a 76 year old male admitted to the agency on 6/16/13, for SN, PT, and OT services related to weakness, fatigue, irregular heartbeat, HTN and venous insufficiency.</p> <p>During a home visit on 5/06/14 beginning at 8:30 AM to observe RN services, Patient #9's wife provided an agency folder that included copies of consents and a calendar that indicated when the various disciplines planned their visits. The folder did not include an aide plan of care. Patient #9 and his wife discussed activities the aide provided, and indicated a specific appliance was used to keep Patient #9's leg dressing dry during bathing. Patient #9's wife brought the appliance into the room to demonstrate how it was used. Patient #9 called it his "Moon Boot."</p> <p>The appliance was not included on the "HOME HEALTH CERTIFICATION AND PLAN OF CARE," for the certification period 4/12/14 to 6/10/14.</p>	G 224	<p>G224 Home Health Aide Services <u>Person Responsible:</u> DDN An in-service was provided to the nurses To give the home health aide a verbal Report at SOC, and provide detailed Written instruction (including DME) On the aide POC. In-service for the C.N.A.'s to complete 12 hours of Training yearly. A copy of the aide POC will be maintained in the clients folder in the home. A joint Visit will be made between the nurse and Aide within 7 days of SOC. Aides will be In-serviced to keep a copy of care plan and provide care according to the POC, and document to the POC. A copy of the aide POC will be maintained in each certification period of the clients chart. Improved written and verbal Communication between the SN and aide will improve client quality of care. Date of Compliance: June 10, 2014 See Exhibits: 1, 2,3,4,5,6,7</p> <p>G224 Addendum Charts will be reviewed 100% until 80% compliant.</p>		

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G 224	<p>Continued From page 35</p> <p>During an interview on 5/08/14 at 3:20 PM, an aide plan of care was requested. The DON provided a copy of a "Care Plan for Home Health Aide" for Patient #9 that was dated 6/16/13. At the bottom of the form were six signatures of RNs followed by dates. The DON stated the dates indicated Patient #9's recertification assessments and the RN's review of his aide plan of care. The DON confirmed the aide plan of care did not include the appliance used to protect his dressings during bathing. The DON was not aware of the specific device used and confirmed there were no specific instructions or precautions included for its use.</p> <p>The aide plan of care did not have specific instructions for all equipment used for Patient #9.</p> <p>2. Patient #11 was an 81 year old woman admitted to the agency on 1/06/14, following a hospitalization for surgical repair of her left hip fracture. Additional diagnoses included HTN and depression. Patient #11's record for the certification period 3/07/14 to 5/05/14 was reviewed. She received SN, PT and aide services during the certification period.</p> <p>Patient #11's record included "CNA PROGRESS NOTES" documenting 20 visits to provide aide services. However, her record did not include an aide plan of care to instruct her aide regarding the care to be provided.</p> <p>A home visit was made to Patient #11's home on 5/07/14 at 10:00 AM to observe a PT visit. During the home visit the agency folder left in the Patient #11's home was reviewed. The folder did not contain an aide plan of care.</p>	G 224			

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G 224	Continued From page 36 During an interview on 5/08/14 at 11:25 AM, the Administrator and the DON reviewed Patient #11's record and confirmed it did not contain an aide plan of care. They were unable to explain why there was no care plan in the record or in Patient #11's home.	G 224		
G 337	Patient #11's record did not contain written patient care instructions for the aide. 484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the drug review was comprehensive for 14 of 14 patients (#1 - #14) whose records were reviewed. This had the potential to place patients at risk for adverse events or negative drug interactions. Findings include: 1. During an interview on 5/08/14, beginning at 10:35 AM, the Administrator and the DON stated the agency had no process in place to review all medications a patient was taking to identify significant interactions between medications. She stated the RN may use a drug book to obtain information about individual medications, but they do not have a system to enter all medications the patient is taking to determine potential interactions between the medications. She	G 337	G337 Drug Regimen Review <u>Person Responsible:</u> DON <u>Plan of correction:</u> A policy and procedure has been established regarding medication reconciliation. When MD has ordered medications the Nurses records the written orders or changes on the medication list and refer to Drugs.com for any possible side effects and notify MD of problem drug interactions. This policy will improve client safety and quality of care provided. <u>Date of Compliance:</u> June 10, 2014 Refer to N173 Refer to Exhibit: 17 G337 Addendum Nurses have been in-serviced as to when a Medication reconciliation is to be performed, How to document and what warrants a call to The MD. The policy and procedure has been Reviewed with the nursing staff, outlining Details of medication reconciliation. Charts will be monitored 100% until they are 80% compliant.	

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G 337	<p>Continued From page 37</p> <p>confirmed the agency did not have a process in place to direct the clinical staff when the patients' physicians were to be notified regarding potential interactions or adverse effects related to medications.</p> <p>However, "Drugs.com," an internationally recognized database and public access website was established as a standard for nurses and clinical staff in determination of drug interactions. A clinician enters all medications into the database and interactions between the medications are identified in 3 categories for severity of interactions as follows:</p> <p>Major - "Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit."</p> <p>Moderate - "Moderately clinically significant. Usually avoid combinations; use it only under special circumstances."</p> <p>Minor - "Minimally clinically significant. Minimize risk, assess risk and consider an alternative drug."</p> <p>After the survey, on 5/13/14, each patients' medications were entered into an the database, as follows:</p> <p>a. Patient #6 was a 92 year old woman admitted to the agency on 3/05/14, for care of a stage II decubitus ulcer. Additional diagnoses included atrial fibrillation, macular degeneration and depression.</p> <p>Patient #6's record included a referral and medical records from her physician's office. The</p>	G 337		

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G 337	<p>Continued From page 38</p> <p>physician's record documented an allergy to Cardizem, which was also documented on her POC for the certification period of 3/05/14 to 5/03/14. The POC and medication profile also documented Patient #6's current medications. The list of medications included Diltiazem (the generic name for Cardizem).</p> <p>Patient #6's record included a comprehensive assessment completed by an RN on 3/05/14. The medication profile sheet, dated 3/05/14, included medications Patient #6 was taking at that time. The medication profile sheet documented the following:</p> <ul style="list-style-type: none"> - Section E of the medication profile stated, "Have potential adverse effects, significant drug interactions, duplicate/ineffective drug therapy and potential contraindications been identified?" The box next to NO was checked. - Section G of the medication profile had a box next to the statement "Medications Reconciled (per agency policy)." The box was unchecked, indicating Patient #6's medications had not been reconciled. <p>A drug interaction check using the website "Drugs.com" was completed on 5/13/14. It indicated 2 major and 9 moderate interactions between Patient #6's medications as listed on her medication profile.</p> <p>During an interview on 5/08/14 at 11:10 AM, the DON and Administrator reviewed Patient #6's record and confirmed her medications were not checked for allergies or drug interactions.</p> <p>Patient #6's comprehensive assessment did not</p>	G 337		

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G 337	<p>Continued From page 39</p> <p>include a review of all medications to determine interactions or potential adverse effects related to her documented allergy.</p> <p>b. Patient #1 was a 63 year old woman admitted to the agency on 7/27/13, following a hospitalization for CHF. Additional diagnoses included uncontrolled DM Type II, atrial fibrillation and pulmonary hypertension. Patient #1's record for the certification period of 9/25/13 to 11/23/13 was reviewed.</p> <p>Patient #1's record included a comprehensive assessment completed by an RN on 7/27/13. The medication profile sheet, dated 7/27/13, included medications Patient #1 was taking at that time. The medication profile sheet documented the following:</p> <ul style="list-style-type: none"> - Section E of the medication profile stated, "Have potential adverse effects, significant drug interactions, duplicate/ineffective drug therapy and potential contraindications been identified?" The box next to NO was checked. - Section G of the medication profile had a box next to the statement "Medications Reconciled (per agency policy)." The box was unchecked, indicating Patient #1's medications had not been reconciled. <p>A drug interaction check using the website "Drugs.com" was completed on 5/13/14. It indicated 3 major and 26 moderate interactions between Patient #1's medications as listed on her medication profile.</p> <p>During an interview on 5/08/14 at 10:30 AM, the DON and Administrator reviewed Patient #1's</p>	G 337		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137102	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/08/2014
NAME OF PROVIDER OR SUPPLIER HELPING HANDS HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 1308 EAST CENTER POCATELLO, ID 83201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 337	<p>Continued From page 40</p> <p>record and confirmed her medications were not checked for drug interactions.</p> <p>Patient #1's comprehensive assessment did not include a review of all medications to determine interactions.</p> <p>c. Patient #8 was a 60 year old woman admitted to the agency on 1/27/14, for uncontrolled DM Type II. Additional diagnoses included an ulcer on her calf, HTN and manic depressive psychosis. Patient #8's records for the certification periods of 1/27/14 to 3/27/14, and 3/28/14 to 5/26/14 were reviewed.</p> <p>Patient #8's record included a comprehensive assessment completed by an RN on 1/27/14. The medication profile sheet, dated 1/27/14, included medications Patient #8 was taking at that time. The medication profile sheet documented the following:</p> <ul style="list-style-type: none"> - Section E of the medication profile stated, "Have potential adverse effects, significant drug interactions, duplicate/ineffective drug therapy and potential contraindications been identified?" The box next to NO was checked. - Section G of the medication profile had a box next to the statement "Medications Reconciled (per agency policy)." The box was unchecked, indicating Patient #8's medications had not been reconciled. <p>A drug interaction check using the website "Drugs.com" was completed on 5/13/14. It indicated 3 major and 22 moderate interactions between Patient #8's medications as listed on her medication profile.</p>	G 337			

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G 337	<p>Continued From page 41</p> <p>During an interview on 5/08/14 at 10:30 AM, the DON and Administrator reviewed Patient #8's record and confirmed her medications were not checked for drug interactions.</p> <p>Patient #8's comprehensive assessment did not include a review of all medications to determine interactions.</p> <p>d. Patient #13 was a 97 year old woman admitted to the agency on 3/12/14, after discharge from a rehabilitation center for care related to a fractured pelvis. Additional diagnoses included HTN, anxiety and history of a stroke.</p> <p>Patient #13's record included a comprehensive assessment completed by an RN on 3/12/14. The medication profile sheet, dated 3/12/14, included medications Patient #13 was taking at that time. The medication profile sheet documented the following:</p> <ul style="list-style-type: none"> - Section E of the medication profile stated, "Have potential adverse effects, significant drug interactions, duplicate/ineffective drug therapy and potential contraindications been identified?" The box next to NO was checked. - Section G of the medication profile had a box next to the statement "Medications Reconciled (per agency policy)." The box was unchecked, indicating Patient #13's medications had not been reconciled. <p>A drug interaction check using the website "Drugs.com" was completed on 5/13/14. It indicated 1 major and 5 moderate interactions between Patient #13's medications as listed on</p>	G 337			

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G 337	<p>Continued From page 42 her medication profile.</p> <p>During an interview on 5/08/14 at 10:30 AM, the DON and Administrator reviewed Patient #13's record and confirmed her medications were not checked for drug interactions.</p> <p>Patient #13's comprehensive assessment did not include a review of all medications to determine interactions.</p> <p>e. Patient #10 was a 75 year old woman admitted to the agency on 11/18/13, for care related to DM Type II and an ulcer on her foot. Additional diagnoses included CHF and chronic kidney disease. Patient #10's record for the certification period 3/18/14 to 5/16/14 was reviewed.</p> <p>Patient #10's record included a comprehensive assessment completed by an RN on 3/17/14. The medication profile sheet, updated 3/17/14, included medications Patient #10 was taking at that time. The medication profile sheet documented the following:</p> <ul style="list-style-type: none"> - Section E of the medication profile stated, "Have potential adverse effects, significant drug interactions, duplicate/ineffective drug therapy and potential contraindications been identified?" The box next to NO was checked. - Section G of the medication profile had a box next to the statement "Medications Reconciled (per agency policy)." The box was unchecked, indicating Patient #10's medications had not been reconciled. <p>A drug interaction check using the website "Drugs.com" was completed on 5/13/14. It</p>	G 337		

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G 337	<p>Continued From page 43</p> <p>indicated 3 major and 18 moderate interactions between Patient #10's medications as listed on her medication profile.</p> <p>During an interview on 5/08/14 at 11:45 AM, the DON and Administrator reviewed Patient #10's record and confirmed her medications were not checked for drug interactions.</p> <p>Patient #10's comprehensive assessment did not include a review of all medications to determine interactions.</p> <p>f. Patient #11 was an 81 year old woman admitted to the agency on 1/06/14, following a hospitalization for surgical repair of her left hip fracture. Additional diagnoses included HTN and depression. Patient #11's record for the certification period 3/07/14 to 5/05/14 was reviewed.</p> <p>Patient #11's record included a comprehensive assessment completed by an RN on 4/22/14. The medication profile sheet, updated 4/22/14, included medications Patient #11 was taking at that time. The medication profile sheet documented the following:</p> <ul style="list-style-type: none"> - Section E of the medication profile stated, "Have potential adverse effects, significant drug interactions, duplicate/ineffective drug therapy and potential contraindications been identified?" This section was not completed. - Section G of the medication profile had a box next to the statement "Medications Reconciled (per agency policy)." The box was unchecked, indicating Patient #11's medications had not been reconciled. 	G 337			

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G 337	<p>Continued From page 44</p> <p>A drug interaction check using the website "Drugs.com" was completed on 5/13/14. It indicated 1 major and 5 moderate interactions between Patient #11's medications as listed on her medication profile.</p> <p>During an interview on 5/08/14 at 11:45 AM, the DON and Administrator reviewed Patient #11's record and confirmed her medications were not checked for drug interactions.</p> <p>Patient #11's comprehensive assessment did not include a review of all medications to determine interactions.</p> <p>g. Patient #5 was a 93 year old woman admitted to the agency on 2/13/14, for care related to difficulty in walking. Additional diagnoses included atrial fibrillation, HTN and depression. Patient #5's record for the certification period of 4/14/14 to 6/12/14 was reviewed.</p> <p>Patient #5's record included a comprehensive assessment completed by an RN on 4/10/14. The medication profile sheet, updated 4/10/14, included medications Patient #5 was taking at that time. The medication profile sheet documented the following:</p> <ul style="list-style-type: none"> - Section E of the medication profile stated, "Have potential adverse effects, significant drug interactions, duplicate/ineffective drug therapy and potential contraindications been identified?" The box next to NO was checked. - Section G of the medication profile had a box next to the statement "Medications Reconciled (per agency policy)." The box was unchecked, 	G 337		

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G 337	<p>Continued From page 45</p> <p>indicating Patient #5's medications had not been reconciled.</p> <p>A drug interaction check using the website "Drugs.com" was completed on 5/13/14. It indicated 3 moderate interactions between Patient #5's medications as listed on her medication profile.</p> <p>During an interview on 5/08/14 at 11:45 AM, the DON and Administrator reviewed Patient #5's record and confirmed her medications were not checked for drug interactions.</p> <p>Patient #5's comprehensive assessment did not include a review of all medications to determine interactions.</p> <p>h. Patient #14's medical record documented an 81 year old male who was admitted to the agency on 4/03/14.</p> <p>His SOC assessment, dated 4/03/14, under locator M2000, indicated no problems were found during the medication review. Locator M2002, "Medication Follow-up," which asks the clinician if the physician was contacted within one calendar day to resolve medication issues, and reconciliation, was left blank.</p> <p>However, a written communication to Patient #14's physician, dated 4/03/14, and stamped to indicate it was faxed to Patient #14's physician on 4/16/14 and 4/23/14, described medication discrepancies noted during the SOC assessment. The form requesting a reply was not signed by Patient #14's physician as of 5/08/14. The request for clarification included the following:</p>	G 337			

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G 337	<p>Continued From page 46</p> <ul style="list-style-type: none"> - D/C Simvastatin - D/C Janumet - Juvisync 100/120 orally, daily - Hydrocodone 10/325 mg 1 tablet orally, four times daily as needed for pain. <p>Additionally, Patient #14's medications were entered into a drug interaction check on the website "Drugs.com." The interaction report included 17 moderate drug interactions between Patient #14's medications.</p> <p>During an interview on 5/08/14 beginning at 3:00 PM, the DON reviewed Patient #14's record and confirmed the clarification of the drugs had not been completed, and his record did not indicate further attempts were made to contact his physician.</p> <p>i. Patient #9 was a 76 year old male admitted to the agency on 6/16/13, for SN, PT, and OT services related to weakness, fatigue, irregular heartbeat, HTN and venous insufficiency.</p> <p>Patient #9's record documented a recertification assessment was performed on 4/10/14. The medication profile was reviewed and updated at that time and included medications Patient #9 was taking. The medication profile sheet documented the following:</p> <ul style="list-style-type: none"> - Section E of the medication profile stated, "Have potential adverse effects, significant drug interactions, duplicate/ineffective drug therapy and potential contraindications been identified?" The box next to NO was checked. - Section G of the medication profile had a box next to the statement "Medications Reconciled 	G 337			

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G 337	<p>Continued From page 47 (per agency policy)." The box was unchecked, indicating Patient #9's medications had not been reconciled.</p> <p>A drug interaction check using the website "Drugs.com" was completed on 5/13/14. It indicated 1 major and 9 moderate interactions between Patient #9's medications.</p> <p>During an interview on 5/08/14 beginning at 3:20 PM, the DON and reviewed Patient #9's record and confirmed a medication reconciliation had not been performed.</p> <p>Patient #9's comprehensive assessment did not include a review of all medications to determine interactions or potential adverse effects.</p> <p>j. Patient #7 was a 59 year old female admitted to the agency on 4/24/14, for SN and home health aide services following discharge from a psychiatric facility for treatment of manic phase of bipolar disorder. Additional diagnoses included Type II DM, anxiety, COPD, HTN, and hepatitis C.</p> <p>An SOC assessment was performed by an RN on 4/24/14. The medication profile sheet, dated 4/10/14 included medications Patient #7 was taking at that time. Discrepancies were noted between the SOC/OASIS assessment and the medication profile as follows:</p> <p>- Section C of the medication profile had a "No" next to the statement "Does the patient demonstrate noncompliance with medication use, as prescribed by physician?" However, the hospital discharge summary, dated 4/24/14, indicated Patient #7 had been noncompliant with her medications in the past, which resulted in</p>	G 337			

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G 337	<p>Continued From page 48 repeated hospitalizations.</p> <p>- Section D of the medication profile had a "Yes" next to the statement "Does patient and/or caregiver have any questions related to current medications, including purpose, dosage, or administration?" There was no further documentation to indicate why a yes answer was marked.</p> <p>- Section E of the medication profile had a "No" next to the statement "Have potential adverse effects, significant drug interactions, duplicate/ineffective drug therapy and potential contraindications been identified?" However, the OASIS assessment, locator M2000 stated problems were found during the medication review. The RN did not clarify on the assessment what problems were found on review.</p> <p>- Section G of the medication profile had a box next to the statement "Medications Reconciled (per agency policy)." The box was unchecked, indicating Patient #7's medications had not been reconciled.</p> <p>Additionally, a drug interaction check using the website "Drugs.com" was completed on 5/13/14. It indicated 33 moderate interactions between Patient #7's medications.</p> <p>During an interview on 5/08/14 beginning at 3:10 PM, the DON and Administrator reviewed Patient #7's record and confirmed the discrepancies noted between the medication profile and admission assessment notes. The DON confirmed Patient #7 had a history of noncompliance with medications during past episodes of her care with the agency. The DON</p>	G 337		

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G 337	<p>Continued From page 49</p> <p>confirmed the agency did not have a policy in which clinicians were directed to notify physicians regarding medication interaction concerns.</p> <p>k. Patient #4's record documented an 83 year old male who was admitted to the agency on 4/13/14, for SN and PT services related to venous insufficiency, difficulty walking, type II DM, an irregular heartbeat, and HTN.</p> <p>An SOC assessment was performed by an RN on 4/13/14. The medication profile sheet, dated 4/13/14 included medications Patient #4 was taking at that time. The medication profile sheet documented the following:</p> <p>- Section G had an unchecked box next to the statement "Medications Reconciled (per agency policy)." The box was unchecked, indicating Patient #4's medications had not been reconciled.</p> <p>A drug interaction check using the website "Drugs.com" was completed on 5/13/14. It indicated 1 major and 12 moderate interactions between Patient #4's medications, with the major interaction being between Coumadin and aspirin.</p> <p>During an interview on 5/08/14 beginning at 2:05 PM, the DON reviewed Patient #4's record and confirmed a medication reconciliation had not been performed. The DON confirmed the agency did not have a policy in which clinicians were directed to notify physicians regarding medication interaction concerns.</p> <p>l. Patient #3's record documented a 66 year female who was admitted to the agency on 9/26/13, for SN services related to a psychiatric diagnosis of paranoid schizophrenia. Patient #3</p>	G 337		

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G 337	<p>Continued From page 50 required an intramuscular injection every other week.</p> <p>An SOC assessment was performed by an RN on 3/20/14. The medication profile sheet included medications Patient #3 was taking at that time. The medication profile sheet documented the following:</p> <p>- Section G had an unchecked box next to the statement "Medications Reconciled (per agency policy)." The box was unchecked, indicating Patient #3's medications had not been reconciled.</p> <p>A drug interaction check using the website "Drugs.com" was completed on 5/13/14. It indicated 1 moderate interaction between Patient #3's Risperdal Consta and benztropine.</p> <p>During an interview on 5/08/14 beginning at 2:20 PM, the DON reviewed Patient #3's record and confirmed a medication reconciliation had not been performed. The DON confirmed the agency did not have a policy in which clinicians were directed to notify physicians regarding medication interaction concerns.</p> <p>m. Patient #12's record documented a 71 year old female who was admitted to the agency on 12/17/13, for SN, aide and PT services related to Lupus (an auto immune disease), CHF, HTN, Type II DM, and abnormal gait.</p> <p>A recertification assessment was performed on 4/15/14. The medication profile sheet included medications Patient #12 was taking at that time. The medication profile sheet documented the following:</p>	G 337		

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G 337	<p>Continued From page 51</p> <p>- Section G had an unchecked box next to the statement "Medications Reconciled (per agency policy)." The box was unchecked, indicating Patient #12's medications had not been reconciled.</p> <p>A drug interaction check using the website "Drugs.com" was completed on 5/13/14. It indicated 2 major interactions, between omeprazole and Citalopram, and fluconazole and Citalopram and 19 moderate drug interactions with the medications Patient #12 was taking.</p> <p>During an interview on 5/08/14 beginning at 2:24 PM, the DON and Administrator reviewed Patient #12's record and confirmed a medication reconciliation had not been performed.</p> <p>14. Patient #2's record documented an 80 year old female who was admitted to the agency on 11/13/13 for SN, PT, OT, aide and ST services related to a stroke, HTN, and history of a fall.</p> <p>A SOC assessment was performed on 11/13/13. The medication profile sheet included medications Patient #2 was taking. The medication profile sheet documented the following:</p> <p>- Section G had an unchecked box next to the statement "Medications Reconciled (per agency policy)." The box was unchecked, indicating Patient #2's medications had not been reconciled.</p> <p>During an interview on 5/08/14 beginning at 2:35 PM, the DON and Administrator reviewed Patient #2's record and confirmed a medication reconciliation had not been performed.</p>	G 337		

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G 337	Continued From page 52 The agency did not ensure medication were reconciled and that physicians were alerted to potential major interactions.	G 337			

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER HELPING HANDS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1308 EAST CENTER POCATELLO, ID 83201
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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the licensure survey of your home health agency conducted from 5/05/14 - 5/08/14. The surveyors conducting the survey were: Susan Costa, RN, HFS - Team Leader Nancy Bax, RN, BSN, HFS Acronyms used in this report include: CPR - Cardiopulmonary Resuscitation DON - Director of Nursing HTN - Hypertension LSW - Licensed Social Worker PT - Physical Therapy	N 000		
N 048	03.07021. ADMINISTRATOR N048 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: b. Providing staff orientation, continuing education, information on applicable laws, rules and policies, resource materials, and staff development to effectively implement and continue the program. This Rule is not met as evidenced by: Refer to G134 and G215.	N 048	N048 <u>Person Responsible:</u> Administrator <u>Plan of Correction:</u> The format for the home health aide program has been restructured to include a Home Health Aide Supplemental checklist upon new hires. Each home health aide will be given yearly competency and performance evaluations, and receive 12 hours of in service each year. The policy and procedure has been revised to reflect these changes. <u>Description of improvement:</u> Competency and Performance evaluations, In-services/Education/orientation, have been revised to coordinate the new employees duties, education and training. Administrator and DON have in-serviced the nursing staff of the importance of training, continued education and monitoring of the C.N.A. With the new hires being educated and trained to the Medicare standards, and records kept current, the care for the clients will be more efficient and effective. <u>Date of Correction:</u> 06-10-2014 Refer to Exhibit: 1,2,3,4,5,6,7,8 Refer to: N048 Addendum The office staff (employee #1) will take the initial information from the new employee or contracted therapist. Employee #1 will create a file for the new employee/contractor. She will also log on a tracking record information regarding, licenses, continuing education, CPR, competency & performance evaluations, security clearance, other ongoing information related to work requirements. Employee #2 will follow up monthly to verify all records are still current. Employee #3 will do a quarterly monitoring of the records to ensure that all records will be current.	RECEIVED JUN 20 2014 FACILITY STANDARDS
N 051	03.07021. ADMINISTRATOR N051 03. Responsibilities. The administrator, or his designee, shall assume responsibility for:	N 051		

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

TITLE

(X6) DATE

Karla Jensen

Administrator

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001245	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2014
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N 051	<p>Continued From page 1</p> <p>e. Personnel records of staff working directly with patients shall include: qualifications, licensure or certification when indicated, orientation to home health, the agency and its policies; performance evaluation, and documentation of attendance or participation in staff development, in-service, or continuing education; documentation of a current CPR certificate; and other safety measures mandated by state/federal rules or regulations.</p> <p>This Rule is not met as evidenced by: Based on review of personnel files and staff interview, it was determined the agency failed to ensure personnel records included current CPR certificates for 5 of 24 staff (Staff C, K, and Q), who provided direct patient care and whose personnel files were reviewed. Failure of the agency to ensure current CPR certification had the potential to compromise patient safety. Findings include:</p> <p>1. On 5/08/14 at 11:55 AM, the DON provided personnel record information relating to 24 staff members. Current CPR certification information was missing for 3 staff members, as follows:</p> <p>a. Staff C, an aide who was hired in April 2008, had a CPR certificate that expired 2/2014.</p> <p>b. Staff K, an aide who was hired in August 2013, had a CPR certificate that expired in 2012.</p> <p>c. Staff Q, an LSW who was hired in September 2013, did not have evidence of a CPR certificate</p>	N 051	<p>N 051 <u>Person Responsible:</u> Administrator <u>Plan of Correction:</u> Personnel records of clinical staff and contracted personnel will be monitored to include the following: qualifications, copy of job description current licensure or certifications, yearly competency and performance evaluations, 12 hours in service yearly, copies of continuing education credits or hours attending, CPR certification and other safety measures mandated by the state/federal rules or regulations. Date of Corrections: 6-10-2014 Refer to Exhibits: 1,2,3,4,5,6,7,8</p> <p>N 051 Addendum The office staff (employee #1) will take the initial information from the new employee or contracted therapist. Employee #1 will create a file for the new employee/contractor. She will also log on a tracking record information regarding, licenses, continuing education, CPR, competency & performance evaluations, security clearance, other ongoing information related to work requirements. Employee #2 will follow up monthly to verify all records are still current. Employee #3 will do a quarterly monitoring of the records to ensure that all records will be current.</p>	
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N 051	Continued From page 2 in her record. During an interview on 5/08/14 beginning at 11:55 AM, the DON confirmed the expired and missing CPR certificates for Staff C, K, and Q. The agency failed to ensure personnel records included current CPR certificates.	N 051		
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 G143.	N 062	N062 Coordination of patient services <u>Person Responsible:</u> D.O.N. <u>Plan of Correction:</u> A new policy and procedure has been written to outline the chain of command for communicating accidents/incidents. The policy also establishes agency parameters for vital signs, O2 sats and pain level, and when to notify the RN and/or MD of any significant change in the patients status. The reporting system will keep the RN and therapies in closer contact and will give the clients better care. <u>Date of Compliance:</u> June 10, 2014 Refer to G 143 Addendum to N062 All staff has been in-serviced on chain of Command for communicating and documenting accident/incidents. Also in-serviced on agency parameters for vital signs, O2 sats, pain level, and when to notify RN and/or MD of any significant change in patients Status. The policy and procedure has been reviewed with all staff, outlining details. We will monitor charts 100% until 80% compliant.	
N 070	03.07022.01.DIRECTOR N070 01. Qualifications. General supervision, coordination, and direction of the medical, nursing, and other services provided shall be the responsibility of a physician or registered nurse. The physician or registered nurse or their designee, who shall be a physician or registered nurse, shall be available at all times during operating hours and shall participate in all activities relative to the professional or other services	N 070		

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N 070	<p>Continued From page 3</p> <p>provided, including the qualifications of personnel as related to their assigned duties.</p> <p>This Rule is not met as evidenced by: Based on review of personnel files and staff interview, it was determined the agency failed to ensure personnel records included current professional licensure for 1 of 11 staff (Staff Q), who required licensure and whose personnel files were reviewed. Failure of the agency to ensure current licensure had the potential to compromise patient safety. Findings include:</p> <p>1. The personnel records for Staff Q, a social worker, included a license which had expired 10/04/13. However, Patient #1's records included notes by Staff Q for services provided during 5 visits, dated 10/04/13, 10/07/13, 10/08/13, 10/10/13, and 10/17/13.</p> <p>During an interview on 5/08/14 beginning at 11:55 AM, the DON and Administrator reviewed Patient #1's record and personnel records for Staff Q and confirmed her license was expired.</p> <p>The facility failed to ensure personnel records included current professional licensure.</p>	N 070	<p>N070 Person Responsible: Administrator <u>Plan of Correction:</u> Personnel records of clinical staff and contracted personnel will be monitored to include the following: current licensure or certifications, yearly competency and performance evaluations; copies of continuing education credits or hours attending, CPR certification and other safety requirements mandated by the state/federal rules or regulations. All updated licenses will be required to maintain employees continued care of clients. Date of Corrections: 6-10-2014 Refer to: Exhibit: 1,2,3,4,5,6,7,8</p> <p>N070 Addendum The office staff (employee #1) will take the initial information from the new employee or contracted therapist. Employee #1 will create a file for the new employee/contractor. She will also log on a tracking record information regarding, licenses, continuing education, CPR, competency & performance evaluations, security clearance, other ongoing information related to work requirements. Employee #2 will follow up monthly to verify all records are still current. Employee #3 will do a quarterly monitoring of the records to ensure that all records will be current.</p>	
N 111	<p>03.07024.03.SK.NSG.SERV.</p> <p>N111 03. Home Health Aide. A home health aide must have completed the supplemental skills checklist approved by the Idaho State Board of Nursing and must be included on the Idaho State Board of Nursing's Home Health</p>	N 111		

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N 111	Continued From page 4 Aide Registry. Duties of a home health aide include the following: a. The performance of simple procedures as an extension of therapy services; This Rule is not met as evidenced by: Refer to G212 and G213.	N 111	N 111 <u>Person Responsible:</u> Administrator <u>Plan of Correction:</u> When hired the C.N.A. must complete The supplemental skills checklist given by the DON/RN. Each home health aide will be given yearly competency and performance evaluations, which include the performance of simple procedures as an extension of therapy services. The policy and procedure has been revised to reflect these changes. <u>Description of improvement:</u> With the new hires being educated and trained to the Medicare standards, and records kept current, the care for the clients will be more efficient and effective. <u>Date of Correction:</u> 06-10-2014 Refer to Exhibit: 1,2,3,4,5,6,7,8	
N 122	03.07024.SK.NSG.SERV. N122 05. Training, Assignment and Instruction of A Home Health Aide. c. Written instructions for home care, including specific exercises, are prepared by a registered nurse or therapist as appropriate. This Rule is not met as evidenced by: Refer to G214 and G224.	N 122	N111 Addendum The office staff (employee #1) will take the initial information from the new employee or contracted therapist. Employee #1 will create a file for the new employee/contractor. She will also log on a tracking record information regarding, licenses, continuing education, CPR, competency & performance evaluations, security clearance, other ongoing information related to work requirements. Employee #2 will follow up monthly to verify all records are still current. Employee #3 will do a quarterly monitoring of the records to ensure that all records will be current. The policy and procedures have been reviewed with The home health aide staff, outlining details Charts will be monitored 100% until 80 % compliant	
N 124	03.07025.01.THERAPY SERV. N124 01. Qualified Therapist. A qualified therapist duties include the following: a. Assists in developing the plan of care and revising it when necessary; This Rule is not met as evidenced by: Refer to G186.	N 124		
N 152	03.07030.01.PLAN OF CARE	N 152		

N122

Person Responsible: Administrator

Plan of Correction:

The format for the home health aide program has been restructured to include a Home Health Aide Supplemental checklist upon new hires. Each home health aide will be given yearly competency and performance evaluations, and receive 12 hours of in service each year. The policy and procedure has been revised to reflect these changes.

Description of improvement:

Competency and Performance evaluations, In-services/Education have been revised to coordinate the new employees duties, education and training. Administrator and DON have in-serviced the nursing staff of the importance of training, continued education and monitoring of the C.N.A.

With the new hires being educated and trained to the Medicare standards, and records kept current, the care for the clients will be more efficient and effective.

Date of Correction:

06-10-2014

Refer to Exhibit: 1,2,3,4,5,6,7

N122 Addendum

The office staff (employee #1) will take the initial information from the new employee or contracted therapist. Employee #1 will create a file for the new employee/contractor. She will also log on a tracking record information regarding, licenses, continuing education, CPR, competency & performance evaluations, security clearance, other ongoing information related to work requirements. Employee #2 will follow up monthly to verify all records are still current. Employee #3 will do a quarterly monitoring of the records to ensure that all records will be current.

The policy and procedures have been reviewed with The home health aide staff, outlining details Charts will be monitored 100% until 80 % compliant

N124 Therapy Services

Person Responsible: Administrator, D.O.N.

Plan of Correction:

The therapists have in-serviced regarding their Roll in developing the plan of care and revising it when necessary. The verbal SOC, recert, resumptions, or change of care orders. They also will notify the case manager of the POC. The therapists have been in serviced regarding this policy. With improved communication between the MD, therapists, and skilled nursing the quality of client care will be significantly improved.

Date of Compliance: June 10, 2014

Refer to Exhibit: 9, 12, 15, 16

N124 Addendum

The policy and procedure has been reviewed With the therapy staff, outlining details. Charts will be monitored 100% until 80% Compliant.

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N 152	Continued From page 5 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 G156.	N 152	N 152 POC <u>Person Responsible:</u> DON & QA RN <u>Plan of Correction:</u> A chart review and oasis review will be initiated with each patient. The staff will be in-serviced for documentation to POC, following MD orders, receiving verbal orders for initial POC, verbally notify MD of any changes to POC. Also in-service staff to pertinent DME that needs to be on 485. All 485 will include PT/OT/MS/ST/C.N.A./SN orders and goals. Policy and procedures to be written pertaining to documentation, verbal SOC orders, all visits to include vital signs, interventions need to be related to 485, notify MD of any changes in condition of the client and any change in the POC. With the improved communication between MD, therapist and skilled nursing quality of care will be significantly improved. Date of Correction: 6-10-2014	
N 155	03.07030. PLAN OF CARE N155 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: c. Types of services and equipment required; This Rule is not met as evidenced by: Refer to G159.	N 155 on following page	Addendum to N152 The policy and procedure has been reviewed With all staff, outlining the details. 100% of the charts will be reviewed until 80 % compliant.	
N 170	03.07030.04.PLAN OF CARE 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 page after 155		

N155 Acceptance of Patients, POC, Med Super

Person Responsible: DON & QA RN

Plan of Correction:

A chart review and oasis review will be initiated with each patient. The staff will be in-serviced for documentation to POC, following MD orders. The staff will list all pertinent DME that needs to be on 485. All 485 will include PT/OT orders and goals. Notify MD of any changes in condition of the client and any change in the POC. With the improved communication between MD, therapist and skilled nursing quality of care will be significantly improved.

Date of Correction: 6-10-2014

Refer to: Exhibit 12, 13, 14

Refer to:

G158: Failure to ensure care as ordered by MD

G159: POC needs to include PT, OT orders and goals

G160: Verbal SOC order r/t POC

G164: Notifying MD of changes in patient condition

N155 Addendum

The policy and procedure has been reviewed With the nursing and therapy staff, outlining Details. There will be 100% chart review Until 80% compliant.

N170 POC

Person Responsible: DON & QA RN

Plan of Correction:

The staff will be in-serviced for following MD orders, receiving verbal orders for initial POC, verbally notify MD of any changes, all changes to be approved by MD

Date of Correction: 6-10-2014

Refer to:

G158: Failure to ensure care as ordered by MD

G159: POC needs to include PT, OT orders and goals

G160: Verbal SOC order r/t POC

G164: Notifying MD of changes in patient condition

N170 Addendum

The policy and procedure has been reviewed

With the nursing and therapy staff, outlining

Details of POC and verbal SOC orders.

Charts will be 100% reviewed until 80%

Compliant.

N172 Acceptance of Patients, POC, Med Super

Person Responsible: DON & QA RN

Plan of Correction:

The Staff will notify Case Manager/RN of any changes in condition of the client and any change in the POC, the Case Manager/RN will notify the MD of any changes in the POC, thereby being able to make needed changes to the other services being provided to the client and maintain continuity of care.

With the improved communication between MD, therapist and skilled nursing quality of care will be significantly improved.

Date of Correction: 6-10-2014

Refer to: Exhibit 9, 10, 11, 12, 13, 14

G158: Failure to ensure care as ordered by MD

G159: POC needs to include PT, OT orders and goals

G160: Verbal SOC order r/t POC

G164: Notifying MD of changes in patient condition

N172 Addendum

The policy and procedure has been reviewed

With the nursing and therapy staff, outlining

Details. There will be 100% chart review

Until 80% compliant.

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N 172	Continued From page 6	N 172		
N 172	03.07030.06.PLAN OF CARE N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This Rule is not met as evidenced by: Refer to G164.	N 172		
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 G337.	N 173	N 173 Drug Regimen Review <u>Person Responsible:</u> DON <u>Plan of correction:</u> A policy and procedure has been established regarding medication reconciliation. When MD has ordered medications the Nurses records the written orders or changes on the medication list and refer to Drugs.com for any possible side effects and notify MD of problem drug interactions. This policy will improve client safety and quality of care provided. <u>Date of Compliance:</u> June 10, 2014 Refer to G337 N173 Addendum Nurses have been in-serviced as to when a Medication reconciliation is to be performed, How to document and what warrants a call To the MD. The policy and procedure has been Reviewed with the nursing staff, outlining Details of medication reconciliation. Charts will be reviewed 100% until 80% Compliant.	
N 186	03.07031.03.CLINICAL REC. N186 03. Clinical and Progress Notes, and Summaries of Care. Clinical and progress notes must be written or dictated on the day service is rendered and incorporated into the clinical record within seven (7) days. Summaries of care reports must be	N 186		

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N 186	<p>Continued From page 7</p> <p>submitted to the attending physician at least every sixty (60) days.</p> <p>This Rule is not met as evidenced by: Based on review of clinical records and staff interview, it was determined the agency failed to ensure clinical notes were placed in patient files within 7 days for 1 of 14 patients (#9) whose clinical records were reviewed. Failure to have progress notes filed in records in a timely manner had the potential to interfere with continuity and coordination of patient care. Findings include:</p> <p>1. Patient #9 was a 76-year-old male whose start of care date was 6/16/13. He received skilled nursing services for care primarily related to a HTN, venous insufficiency, and weakness.</p> <p>Patient #9's record included physician orders, dated 4/10/14, for PT visits two to three times per week for the duration of the certification period of 4/12/14 to 6/10/14. There was no documentation found in the clinical record that a second PT visit was performed the week of 4/27/14.</p> <p>During an interview on 5/08/14 beginning at 3:20 PM, the DON and Administrator reviewed Patient #9's record and confirmed PT notes for a second visit the week of 4/27/14 were not in the record. The DON stated the therapists have been instructed to turn in their notes every Monday, and she was not able to locate additional notes for Patient #9. The Administrator stated she had difficulty with the therapy staff turning notes in to the agency in a timely manner. She stated it was the agency's policy to have progress notes filed within 7 days.</p> <p>The agency failed to ensure clinical notes were</p>	N 186	<p>N186 Therapy Services <u>Persons Responsible:</u> Administrator, D.O.N. <u>Plan of Correction:</u> The therapists will be in serviced regarding the Verbal SOC, recert, resumptions, or change of care orders. They will also be in serviced to notify the case manager of the POC. PT and OT orders, interventions, and goals will be included on the 485. A policy and procedure has been implemented regarding therapist responsibilities. The therapists have been in serviced regarding this policy. With improved communication between the MD, therapists, and skilled nursing the quality Of client care will be significantly improved. Date of Compliance: June 10, 2014</p> <p>Refer to Exhibit: 9, 12, 15, 16</p> <p>N186 Addendum The policy and procedure has been reviewed With the therapy staff, outlining details. Charts will be monitored 100% until 80% Compliant.</p>	

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N 186	Continued From page 8 placed in patient files within 7 days.	N 186	N199 Criminal History <u>Person Responsible:</u> Administrator <u>Plan of Correction</u>	
N 199	<p>Criminal History and Background Check</p> <p>009.CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.</p> <p>01. Compliance with Department ' s Criminal History and Background Check. A home health agency must comply with IDAPA 16.05.06, " Criminal History and Background Checks. " (3-26-08)</p> <p>02. Direct Patient Access Individuals. These rules apply to employees and contractors hired or contracted with after October 1, 2007, who have direct patient access. (3-26-08)</p> <p>03. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must complete an application before having access to patients. If a disqualifying crime as described in IDAPA 16.05.06, " Criminal History and Background Checks, " is disclosed, the individual cannot have access to any patient without a clearance by the Department. Once the notarized application is completed the individual can only work under supervision until the individual has been fingerprinted. The individual must have his fingerprints submitted to the Department within twenty-one (21) days of completion of the notarized application. (3-26-08)</p> <p>This Rule is not met as evidenced by: Based on review personnel files and staff interview, it was determined the agency failed to ensure personnel records included criminal background checks for 1 of 24 staff (Staff S), who</p>	N 199	<p>Office staff will be in-serviced and Re-assigned task that will have a check and balance for checking for security clearances, licensing, CPR, insurance, in-services and any other Credentialing. Staff member 1 will record the initial documentation in the employees binder. A chart showing the dates for re-certifying of the necessary documentation, and Staff member 2 will review monthly for any out of date, licensing and other needed records for the employee. The security clearance will have staff member 2 ensure that the proper form from the criminal background is copied and put in the employee file. Compliance by June 10, 2014 Refer to Exhibit 18</p> <p>N199 Addendum The office staff (employee #1) will take the initial information from the new employee or contracted therapist. Employee #1 will create a file for the new employee/contractor. She will also log on a tracking record information regarding, licenses, continuing education, CPR, competency & performance evaluations, security clearance, other ongoing information related to work requirements. Employee #2 will follow up monthly to verify all records are still current. Employee #3 will do a quarterly monitoring of the records to ensure that all records will be current.</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001245	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2014
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NAME OF PROVIDER OR SUPPLIER HELPING HANDS HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1308 EAST CENTER POCATELLO, ID 83201
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 199	<p>Continued From page 9</p> <p>provided direct patient care and whose personnel files were reviewed. Failure of the agency to ensure criminal background checks were completed had the potential to compromise patient safety. Findings include:</p> <p>1. Personnel records for Staff S, who was hired in February 2008, did not include a criminal history and background check.</p> <p>During an interview on 5/08/14 beginning at 11:55 AM, the DON stated Staff S was an active contracted therapist that provided patient care for multiple patients each week and the Administrator and DON confirmed Staff S's personnel record did not include the required documents.</p> <p>The agency failed to ensure personnel records included criminal background checks.</p>	N 199		