IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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CERTIFIED MAIL: 7007 3020 0001 4038 8508

May 21, 2013

COPY

Lori Asay, Administrator
Intermountain Home Care Of Cassia
1031 E Main Street
Burley, ID 83318-2029

RE: Intermountain Home Care Of Cassia, Provider #137016

Dear Ms. Asay:

Based on the survey completed at Intermountain Home Care Of Cassia, on May 10, 2013, by our staff, we have determined Intermountain Home Care Of Cassia is out of compliance with the Medicare Home Health Agency (HHA) **Condition of Participation of Acceptance of Patients, POC, Medical Supervision (42 CFR 484.18)**. To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

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

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

An acceptable Plan of Correction contains the following elements:

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

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

Such corrections must be achieved and compliance verified by this office, before June 24, 2013. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than June 14, 2013.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **June 3, 2013**.

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

We urge you to begin correction immediately.

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

Sincerely,

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137016	A. BUILDING _____ B. WING _____	05/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERMOUNTAIN HOME CARE OF CASSIA	1031 E MAIN STREET BURLEY, ID 83318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your home health agency. The surveyors conducting the recertification were: Libby Doane, BSN, RN, HFS - Team Leader Susan Costa, RN, HFS Don Sylvester, RN, HFS Acronyms used in this report include: ALF - Assisted Living Facility BG - Blood Glucose BPH - Benign Prostatic Hyperplasia CKD- Chronic Kidney Disease DME - Durable Medical Equipment ER - Emergency Room gm - gram HHA - Home Health Aide INR - International Normalized Ratio - a test to determine the clotting tendency of blood IV - Intravenous lb - pound mcg - microgram mEq - milliequivalent mg - milligram ml - milliliter NS - Normal Saline pt - patient PT - Physical Therapy PTA - Physical Therapy Aide POC - Plan of Care RN - Registered Nurse s/s - signs and symptoms SQ - Subcutaneous/Subcutaneously SN - Skilled Nursing SOC - Start of Care	G 000	RECEIVED JUN - 7 2013 FACILITY STANDARDS	

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

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

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G 000	Continued From page 1 tsp - teaspoon	G 000		
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on observation, patient interview, medical record review and staff interview, it was determined the agency failed to ensure POCs were followed, that the POCs included all pertinent diagnoses, the physician was notified if the POCs were altered or patients' conditions changed, drugs and treatments were administered as ordered by the physician, and that verbal orders were signed and dated. Failure to provide care in accordance with a thorough POC had the potential to interfere with progress toward discharge from the agency. Findings include: 1. Refer to G158 as it relates to the failure of the agency to ensure care was provided in accordance with POCs. 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. 3. Refer to G164 as it relates to the failure of the agency to notify the physician with changes in patients' conditions. 4. Refer to G165 as it relates to the failure of the agency to ensure drugs and treatments were administered by staff only upon a physician's	G 156		6/14/13

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G 156	Continued From page 2 order. 5. Refer to G166 as it related to the failure of the agency to ensure verbal orders were put in writing, signed and dated. The cumulative effect of these negative systemic practices impeded the agency in providing quality care in accordance with established POCs.	G 156		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review, and patient and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 4 of 12 patients (#2, #6, #8, and #12) whose records were reviewed. This resulted in unauthorized treatments as well as omissions of care and had the potential to result in unmet patient needs. Findings include: 1. Patient #6 was a 52 year old female who was admitted to the agency on 4/15/13 following hospitalization for a right below the knee amputation secondary to diabetes and an infection in her bones. The POC for the certification period 4/25/13 to 6/23/13 noted "Physical Therapy to evaluate/treat ...", and included one visit the first week of the certification period. The first PT visit was noted on 4/29/13, the second week of the certification period.	G 158	Provide care according to plan of care established by the physician Nurse Manager to: • Educate staff regarding process of review of physician orders prior to providing care and notification of physician if unable to provide care as ordered. • Educate staff regarding notifying physician of changes in patient condition to obtain orders for care prior to providing care • An audit of changes in patient condition and documentation of physician notification will determine if the patient's physician was notified of changes in the patient's condition. Audit indicators to be collected on 100% of patients discussed in weekly interdisciplinary team meeting. Audit to begin 5/21/13. Audit results to be at 90% compliance by 6/14/13. 5/14/13 – Staff educated regarding expectation for review of physician order prior to providing care and need to contact physician for orders related to change in patient condition prior to providing care 5/14/13 - Staff educated regarding notification of physician if unable to provide care as ordered.	6/14/13

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G 158	Continued From page 3 During the entrance conference on 5/06/13 beginning at 11:30 AM, the Physical Therapist stated when therapy services are ordered, a therapist will see a patient for evaluation within 2 days. A second interview on 5/09/13 beginning at 1:15 PM, the Physical Therapist reviewed Patient #6's medical record and confirmed the PT evaluation was completed on 4/29/13. She stated due to her schedule and the weekend, it was not possible to see Patient #6 until the second week of the certification period. PT did not evaluate Patient #6 the first week in accordance with the POC. 2. Patient #12 was a 68 year old female whose SOC was 6/08/12. Her diagnoses included pyelonephritis, chronic bronchitis, and dementia. Her medical record for the certification period of 4/04/13 through 6/02/13 was reviewed. An RN visit note for 4/22/13 at 11:19 AM documented a stage 2 pressure ulcer on Patient #12's right buttock, first observed on that visit. The RN also documented on this visit note that she cleaned the pressure ulcer with NS and applied a foam dressing. There was no documentation to indicate the physician had been notified of the pressure ulcer or given orders for treament. An RN visit note from 4/25/13 at 2:05 PM documented the RN had again cleaned the ulcer to Patient #12's right buttock with NS and applied a foam dressing. There was no documentation in the medical record to indicate a phsyicain had	G 158		

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G 158	Continued From page 4 been notified of this ulcer or given orders for treatment The RN case manager reviewed the record and was interviewed on 5/09/13 at 3:25 PM. She stated she had notified the physicain of the new wound and had recieved orders for treament. She produced an order enetered into the agency computer system on 5/09/13 at 2:53 PM. The order stated it was a late entry from 5/1/13 and included treament orders for the wound. The RN confirmed that this order was not present when she treated the wounds on 4/22/13 and 4/25/13. SN adminstered wound treatments without an order. 3. Patient #2 was an 88 year old male admitted to home health services 4/16/13 for SN, HHA and PT services following a recent hospitalization. His diagnoses included CKD, BPH, atrial fibrillation and abnormal gait. Patient #2 did not recieve care in accordance with the POC as follows: a. Patient #2's POC for the certification period 4/16/13 to 6/14/13 included PT for evaluation, treatment and education. A "PT eval" dated 04/16/13, included a plan for 2-3 visits weekly for 4 weeks. The medical record did not include evidence of the Physical Therapist's communication with the physician for verbal orders. During an interview on 5/09/13 at 1:15 PM, the Physical Therapist confirmed verbal orders had not been obtained. She explained the PT	G 158		

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G 158	Continued From page 5 evaluation was reviewed by the Nurse Manager, and she would be responsible for securing a physician's order. She presented an order request, dated 4/22/13 that was sent to Patient #2's physician. The order request was signed by the physician on 5/02/13. The Physical Therapist confirmed four PT visits dated 4/23/13, 4/26/13, 4/29/13, 5/01/13 had occurred before physician orders had been obtained. b. Patient #2's POC for the certification period 4/16/13 to 6/14/13 stated SN visits were to include oxygen saturations. Oxygen saturations were not documented during SN visits dated 04/16/13, 04/17/13, 04/19/13, 0422/13, 04/24/13, 04/29/13. An interview on 5/07/13 at 4:30 PM, the RN case manager confirmed the oxygen saturations had not been documented. She stated Patient #2 was not on oxygen therefore she felt no need to assess oxygen saturations. Care was not provided to Patient #2 in accordance with the POC. 4. Patient #8 was a 90 year old female admitted to the agency on 4/10/13 for SN management of insulin dependent diabetes. At the time of the survey, Patient #8 was living in an ALF. Her medical record for the certification period of 4/10/13 through 6/08/13 was reviewed. Her POC, signed by the physician on 4/30/13, included orders for SN to visit four times a day to administer insulin and assess diabetic status.	G 158		

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G 158	Continued From page 6 An RN visit note from 4/22/13 at 9:54 PM documented the RN entered the ALF and was informed Patient #8's BG was 56. A staff member from the ALF reported to the RN that Patient #8 had already begun drinking juice to try to raise her BG. The ALF staff member told the RN that Patient #8 would check her blood sugar "after a while." The RN then "asked (the staff member) if it was over 150, if I have to come back and she said no, that it evens out by morning." The RN ensured Patient #8 was drinking and then left the ALF at 10:20 PM, telling Patient #8 she would be back to check on her in the morning. The RN did not check Patient #8's BG before leaving. The agency policy "Diabetic Hypoglycemia Pediatric Adult Protocol," undated, stated that a BG below 70 in adults is considered hypoglycemia and should be treated. The policy stated that treatment involved administering oral glucose tablets, juice, milk or honey to raise the patient's blood sugar. The policy stated that the BG was to be rechecked 15 minutes after treatment and to retreat if BG remained below 70. If the BG remained below 70 after two treatments the physician was to be notified. The RN was interviewed on 5/09/13 at 1:40 PM. She confirmed she did not stay to recheck the BG. She stated she was unsure of the protocol and did not want to call the case manager as it was late at night. She confirmed that by not rechecking Patient #8's blood sugar per policy, she could not have known if the treatment of drinking juice had been effective in raising Patient #8's BG.	G 158		

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G 158	Continued From page 7 Patient #8's diabetic status was not assessed by the RN as required in the 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, patient and staff interview, and observation, it was determined the agency failed to ensure the plan of care included all pertinent information for 4 of 12 patients (#4, #9, #10, and #11) whose records were reviewed. This had the potential to interfere with continuity and completeness of patient care. Findings include: 1. Patient #11 was an 81 year old female with a SOC of 2/14/13. Her diagnoses included CHF, HTN, and abnormal gait. The POC for the certification period 4/15/13 to 6/13/13 included orders for SN, HHA, and PT services. The POC was individualized to Patient #11's needs and and did not include all pertinent information as follows: - The POC included a single point cane, walker, and quad cane as DME. PT evaluation notes dated 4/10/13, stated Patient #11 used a bedside commode, shower bench, and oxygen.	G 159	Plan of care to be developed according to patient specific assessments and needs. All physicians participating in the plan of care will be found in the electronic record. Nurse Manager to: • Educate staff regarding updating plan of care to include listing all DME used by the patient. • Documentation to include identification and education regarding use and safety of any DME obtained after start of care. • Plan of care to be updated with DME used by patient at each recertification if applicable • An audit of in-home assessments will determine if DME in the home, and DME listed on the plan of care are consistent. Audit indicators to be collected during 100% of shared visits, manager rounding visits and clinician to clinician when multiple disciplines are providing care. Audit to begin 5/21/13. Audit results to be at 90% compliance by 6/14/13. 5/14/13 – Staff educated regarding developing plan of care specific to individual patient assessment and needs including updating plan of care at recertification with any equipment and supplies obtained after the start of care, documenting identification and education regarding use and safety of any DME obtained after start of care	6/14/13

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G 159	Continued From page 8 - The POC included instructions for the nurse to assess and instruct Patient #11 to avoid alcohol, smoking cessation, avoid NSAIDS (non-steroidal anti-inflammatory drugs), and keep a daily journal of weight, fluid intake, blood pressure, and heart rate. The RN Case Manager was interviewed on 5/09/13 beginning at 11:30 AM. She reviewed Patient #11's record and confirmed the DME in Patient #11's home had not been included in the POC. She reviewed the POC and stated Patient #11 was not a smoker, did not drink alcohol, and was not able to maintain a daily journal. The nurse confirmed the POC was not patient specific. She stated the software program would pre-populate the interventions based on the patient's diagnoses. The nurse stated the interventions would be the same for all patients with that diagnoses, but it was possible to personalize for each patient. The POC for Patient #11 did not reflect her unique and individualized needs. 2. Patient #10 was a 5 year old male admitted to the agency on 1/06/12 for SN services related to cystic fibrosis. His POC for the certification period 4/14/13 to 6/12/13 did not include the following: - The POC included "Infusion supplies," but was not specific as to what those were. - The "RN RECERT VISIT" note, dated 4/09/13 at 12:22 PM, documented Patient #11 had a port central line in his upper chest. The note also	G 159	Plan of care to be developed according to patient specific assessments and needs. • Audit of all plan of care orders for 100% of admissions and recertifications to determine if individualization of the plan of care is specific to assessed needs of patient to be done by central audit team and by clinical staff in weekly interdisciplinary team meeting. Audit to begin 5/21/13. Audit results to be at 90% compliance by 6/14/13. • Educate staff regarding asking physician for patient specific parameters for notification. • Work with medical director to establish agency parameters when not specified by patient's attending physician. • Audit for patient specific parameters for notification or documentation of discussion of specific parameters with physician will be done on 100% of patients discussed in weekly interdisciplinary team meeting to begin 5/21/13. Audit results to be at 90% compliance by 6/14/13 5/14/13 – Staff educated regarding editing standard order text specific to patient assessment and asking physician for patient specific parameters for notification 5/21/13 – Audit began by central audit team to determine if plan of care is specific to patient's assessed needs. 5/21/13 – Began discussion of patient specific plan of care and audit of plan of care orders during interdisciplinary team meeting.	6/14/13

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G 159	Continued From page 9 documented Patient #11 had a percussion vest for respiratory treatments. These items were not listed on the POC. - RN visit notes from 4/26/13 at 5:02 PM documented Patient #11 had a feeding tube that required a pump. These items were not listed on the POC. During an interview on 5/09/13 beginning at 11:20 AM, the RN Case Manager confirmed Patient #10 had the above listed items and they were not included on the POC. She stated the present software program the agency used pre-populated the POC with the information from the previous certification period. The nurse stated she had not verified the POC to confirm for accuracy before she signed the form. The POC for Patient #10 was not specific and complete. 3. Patient #9 was a 6 month old female admitted to the agency on 1/15/13. Her diagnoses included extreme prematurity and chromosomal abnormalities. The POC for the certification period 3/17/13 to 5/15/13 included one physician, a general practitioner. An RN visit note, dated 4/22/13 at 3:30 PM, documented Patient #9 had been in the hospital for 1 week due to a viral illness. The visit note included documentation Patient #9 was also under the care of a cardiologist and plastic surgeon. The additional physicians were not included on the POC. During an interview on 5/09/13 beginning at 3:00	G 159		

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G 159	Continued From page 10 PM, the RN Case Manager reviewed the record and confirmed Patient #9 had a cardiologist and a plastic surgeon, as well as a neonatologist in another town. She confirmed she had not included these physicians on the POC. The POC did not include all of Patient #9's physicians. 4. Patient #4 was 90 year old female whose SOC was 04/05/12. Her diagnoses included pneumonia and dementia. Her medical record for the certification period of 4/05/12 through 6/03/12 was reviewed. The POC, signed by the physician 4/18/12, included orders for oxygen and IV antibiotics to treat the pneumonia. The POC also included orders for SN to assess Patient #4's respiratory status and obtain an oxygen saturation level, or O2 sat, on every visit. Oxygen saturation levels as defined in "Procedure Manual for Critical Care, Fourth Edition," indicate the percentage of hemoglobin saturated with oxygen. A normal value would be 97% to 99% in a healthy individual. Values under 90% would be considered low. The POC did not include parameters of what constituted a low O2 sat level which required the physician to be notified. In addition, the agency did not have a policy to define its own parameters if the physician does not order any. During an interview at 10:55 AM on 5/09/13, the Nurse Manager confirmed there was not an agency policy that defined the parameters to call the physician for O2 sats or any other vital sign. The Nurse Manager stated parameters should be patient specific and included on the POC. She	G 159		

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INTERMOUNTAIN HOME CARE OF CASSIA	1031 E MAIN STREET BURLEY, ID 83318

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G 159	Continued From page 11 agreed that without a policy or parameters documented on the POC, each nurse is using her own judgement as to what constituted a low O2 sat. Parameters for oxygen saturation levels were not included on the POC.	G 159		
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records and policies, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the plan of care for 4 of 12 patients (#3, #4, #5, and #9) whose records were reviewed. This resulted in missed opportunity for physicians to alter the plan of care to meet patient needs. Findings include: 1. Patient #3 was a 69 year old male whose SOC was 4/03/13 following a below the knee amputation of his left leg. His medical record for the certification period of 4/04/13 through 6/02/13 was reviewed. A "Request for Discharge Orders from [Rehabilitation Facility]," signed by the physician on 4/03/13, untimed, included orders for nursing and therapy services to evaluate Patient #3.	G 164	All changes in patient condition to be reported to patient's physician and contacts with physician to be documented Nurse Manager to: • Educate staff regarding notification of physician for patient changes suggestive of a need to alter the plan of care. • Discuss changes in patient condition in interdisciplinary team meeting. • An audit of changes in patient condition and documentation of physician notification will determine if the patient's physician was notified of changes in the patient's condition. Audit indicators to be collected on 100% of patients discussed in weekly interdisciplinary team meeting. Audit to begin 5/21/13. Audit results to be at 90% compliance by 6/14/13.	6/14/13

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G 164	Continued From page 12 The POC, signed by the physician on 4/24/13 at 5:05 PM only documented orders for SN. There were no therapy orders on the POC. On 4/25/13 at 12:29 PM an order was entered for PT to evaluate and treat, 22 days after the initial order. There was no documentation in the medical record to indicate why Patient #3 had not received therapy as initially ordered. The RN case manager reviewed the record and was interviewed on 5/09/13 at 1:40 PM. She stated that during her initial assessment of Patient #3 on 4/04/13, Patient #3's wife stated she did not think Patient #3 would benefit from PT at that time. She also stated that at the time of admission, Patient #3 had several wounds to his left leg that needed to heal before PT could be initiated. She confirmed there was no documentation in the medical record to indicate Patient #3's physician had been notified that, due to Patient #3's condition, therapy services had been delayed. The physician was not notified of changes in Patient #3's treatment. 2. Patient #4 was a 90 year old female whose SOC was 4/05/12. Her diagnoses included pneumonia and dementia. Her medical record for the certification period of 4/05/12 through 6/02/12 was reviewed. a. Patient #4's physician was not notified of changes in her condition related to wounds as follows: i. An RN visit note from 4/13/12 at 11:15 AM	G 164	5/14/13 - Staff educated regarding notification of physician for changes in patient condition and documentation of physician contact 5/21/13 – Began discussion of changes in patient condition and audit of documentation of physician notification of changes in patient condition during interdisciplinary team meeting.	

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G 164	Continued From page 13 documented Patient #13 had an abrasion to her right lower back. There was no documentation to indicate the physician had been notified of the abrasion. An RN visit note from 4/15/12 at 11:05 AM documented the same wound but also documented a pressure ulcer to Patient #4's coccyx. There was no documentation to indicate Patient #4's physician had been notified of the pressure ulcer. The Nurse Manager reviewed the record and was interviewed on 5/09/13 at 4:15 PM. She confirmed there was no documentation to indicate SN had notified the physician of the abrasion to Patient #4's back. She also confirmed there was no documentation to indicate the physician had been notified of the pressure ulcer to Patient #4's coccyx. ii. An RN visit note for 4/18/12 at 9:43 AM documented Patient #4 had fallen in her room that day. The visit note also contained documentation and pictures of injuries sustained from the fall, including a right knee abrasion and skin tear on the right third finger. There was no documentation to indicate Patient #4's physician had been notified of the fall or subsequent injuries. The RN that documented the visit note on 4/18/13 at 9:43 AM reviewed the record and was interviewed on 5/09/13 at 10:55 AM. She stated that agency's protocol was to notify the physician of every fall, especially if injuries were sustained. She confirmed there was no documentation to indicate Patient #4's physician was notified of her	G 164		

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G 164	Continued From page 14 fall or injuries as per protocol. b. The POC included orders for SN to assess Patient #4's respiratory status and obtain an oxygen saturation level, or O2 sat, on every visit. Oxygen saturation levels as defined in "Procedure Manual for Critical Care, Fourth Edition," indicate the percentage of hemoglobin saturated with oxygen. A normal value would be 97% to 99% in a healthy individual. Values under 90% would be considered low. The POC did not include parameters of what constituted a low O2 sat level which required the physician to be notified. In addition, the agency did not have a policy to define its own parameters if the physician does not order any. The lack of defined parameters lead to a failure to coordinate care within skilled nursing services and report changes in condition as follows: i. RN visit notes for 4/05/12 at 6:20 PM documented Patient #4's O2 sat was 47% on room air. The RN documented the O2 sat level increased to 87-88% with oxygen applied. There was no documentation that the physician had been notified of these O2 sat levels. The RN that documented the note reviewed the record and was interviewed on 5/09/13 at 3:25 PM. She confirmed she had not notified the physician of the O2 sat levels. She stated that she had reviewed Patient #4's history and used her nursing judgement to determine an O2 sat of 88% was "as good as she was going to get." She stated she was unaware of an agency policy that defined the parameters to call the physician for O2 sats.	G 164		

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G 164	Continued From page 15 ii. RN visit notes for 4/07/12 at 4:12 PM documented Patient #4's O2 sat was 86-87 while on oxygen. There was no documentation to indicate the physician had been notified of this O2 sat. The RN that documented the note reviewed the record and was interviewed on 5/09/13 at 1:40 PM. She confirmed she had not notified the physician of Patient #4's oxygen saturations. She stated that she had used her nursing judgment at that time as there were no parameters ordered by the physician. She stated she was unaware of an agency policy that defined the parameters to call the physician for O2 sats. iii. RN visit notes for 4/13/12 at 11:15 AM documented Patient #4's O2 sat as 84-85% while wearing oxygen. There was no documentation to indicate the physician had been notified. The RN that documented the note reviewed the record and was interviewed on 5/09/13 at 1:40 PM. She confirmed she had not notified the physician of Patient #4's oxygen saturations. She stated that she had used her nursing judgment at that time as there were no parameters ordered by the physician. She stated she was unaware of an agency policy that defined the parameters to call the physician for O2 sats. iv. RN visit notes for 4/14/12 at 10:50 AM documented Patient #4's O2 sats were 64-74% while on oxygen. The RN also documented that Patient #4 was actively participating in conversation. There was no documentation in the medical record to indicate the physician had been notified of the O2 sat.	G 164		

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G 164	Continued From page 16 The RN that documented the note reviewed the record and was interviewed on 5/09/13 at 10:55 AM. She confirmed she had not notified the physician of Patient #4's oxygen saturations. She confirmed that Patient #4's O2 sats had become progressively worse by this point. She stated that she had not called the physician because Patient #4 was actively conversing with her and did not appear to be in distress. She acknowledged she was unaware of an agency policy that defined the parameters to call the physician for O2 sats. Patient #4's physician was not notified of changes in her condition. 4. Patient #9 was a 6 month old female admitted to the agency on 1/15/13. Her diagnoses included extreme prematurity and chromosomal abnormalities. The POC for the certification period 3/17/13 to 5/15/13 included "SN to assess infant's nutritional status, ...parents ability to safely care for high risk infant, Mother has developmental delay." Patient #9 ' s medical record was reviewed. Nursing visit notes showed Patient #9 experienced weight loss 5 times from 3/15/13-4/12/13 as follows: - 3/15/13, weight 7 lb 4 oz. - 3/19/13, weight 7 lb 3.5 oz. (loss) - 3/22/13, weight 7 lb 2 oz. (loss) - 3/26/13, weight 7 lb 3.5 oz. - 3/28/13, weight 7 lb 3 oz. (loss) - 4/02/13, weight 7 lb 2.5 oz. (loss) - 4/05/13, weight 7 lb 4 oz. - 4/09/13, weight 7 lb 6.5 oz.	G 164		

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G 164	Continued From page 17 - 4/12/13, weight 7 lb 4 oz. (loss) An "RN VISIT," dated 4/12/13 at 11:39 AM, documented Patient #9 had a pain level of 2 and required the use of pain medications 2-3 times daily. The visit note documented Patient #9 had an increased respiratory rate of 66 breaths per minute, a loose cough, and respiratory sounds were "slight rubbing." Her skin was pale and she was noted as having tan colored thick drainage in her eyes. The visit note included "Pt lost 2.5 oz. pt with matty eyes and increased resp rate, lose (sic) freq cough, and decreased intake. Pt with s/s of infection. Parents will take pt to ER tonight after Father gets off work follow up with any changes or possible hospitalization." A subsequent "RN VISIT," dated 4/22/13 at 3:30 PM, documented Patient #9 had been in the hospital for 1 week due to a viral illness. During an interview on 5/09/13 beginning at 3:00 PM, the RN Case Manager reviewed Patient #9's medical record and confirmed the documentation of frequent weight loss. She confirmed she had not alerted Patient #9's attending physician regarding the above weight losses and illness. The nurse did not notify the attending physician of changes in Patient #9's condition. 5. Patient #5 was a 2 year old female admitted to the agency on 5/09/11 for SN services related to feeding problems and chromosomal abnormalities. The following medications were listed on Patient #5's POC for the certification period of 4/28/13 through 6/26/13:	G 164		

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G 164	Continued From page 18 - Glycerin liquid, 0.5 ml as needed for constipation, - Miralax 17 gm/dose powder, 1/2 tsp oral as needed 1-2 times daily as needed to prevent constipation, - Antipyrine-benzocaine 5.4, 3-4 drops every 4 hours to ears as needed for pain, - Pediasure 1.5 with fiber, 1 as needed. In addition, the POC included Similac formula and baby foods as nutritional requirements. During a SN home visit on 5/08/13 starting at 10:00 AM, surveyors completed a review of medications with Patient #5's mother. She stated she had not used the glycerin liquid or the ear drops for more than a year. Patient #5's mother stated her baby no longer took Similac and baby foods, she was eating table food, and drank Pediasure for additional calories. In addition, she stated Patient #5 was taking children's gummy multivitamins. The gummy multivitamins were not included in Patient #5's medication profile and POC. During an interview on 5/09/13 at 3:00 PM the RN who provided care for Patient #5 reviewed the medical record. She stated she was unaware that Patient #5 was taking the multivitamins. She stated she was unaware Patient #5's mother had stopped the ear drops and glycerin liquid. She stated she did not review Patient #5's medications at each visit. Patient #5's physician had not been notified of changes in her status that reflected a need to change her POC.	G 164		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN	G 165		6/14/13

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G 165	Continued From page 19 ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure medication was administered as ordered by the physician for 1 of 12 patients (#8) whose records were reviewed. This resulted in unauthorized medication administration which had potential to negatively impact patient safety. Findings include: 1. Patient #8 was a 90 year old female whose SOC was 4/10/13. Her diagnoses included insulin dependent diabetes. Her medical record for the certification period of 4/10/13 through 6/08/13 was reviewed and contained the following: Patient #8's POC, signed by the physician on 4/30/13, included orders for the RN to administer insulin based on Patient #8's BG level, or a sliding scale. The POC included a different sliding scale to be used for lunch, dinner and bedtime. An RN visit note for 11:24 AM on 4/28/13 documented Patient #8's BG was 238. The note also documented that the RN experienced difficulty with the insulin pen while administering the insulin. She documented that she was supposed to "give 24 units, pen went down to 14 and stopped. After I removed needle from pt and gone to ask staff if they had any similar	G 165	Medication and treatment to be administered according to physician orders and documented consistently Nurse Manager to: • Educate staff regarding process of review of physician orders prior to administrating medications. • Educate staff regarding coordination of care between all disciplines as needed for change in plan of care and during weekly interdisciplinary team meeting prior to recertification. Case manager to discuss multi-disciplinary plan of care with physician when obtaining recertification orders. • A daily audit of any medications administered by home health nursing staff will determine if medications are administered according to physician's orders. Audit indicators to be collected on 100% of patients with medications administered by home health nursing staff. Audit to begin 5/20/13. Audit results to be at 90% compliance by 6/14/13. 5/14/13 – Staff educated regarding expectation for review of physician order prior to providing care. 5/21/13 – Began coordination of care between all disciplines during interdisciplinary team meeting. 5/21/13 Began daily medication audit for medications administered according to physician order	6/14/13

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G 165	Continued From page 20 experiences, insulin started shooting out of the pen. I returned to pt and gave the remaining 14 units with no problems." According to the note, the RN administered a total of 28 units of insulin - two doses of 14 units. In the note she documented she had intended to administer 24 units. However, according to the sliding scale on the POC for lunch, the amount of insulin prescribed for a BG of 238 should have been 22 units. The documentation in the medical record indicated the RN gave Patient #8 six more units of insulin than had been ordered. The RN reviewed the record and was interviewed on 5/09/13 beginning at 1:40 PM. She confirmed the documentation indicated she had given more insulin than had been ordered. Insulin was not administered as ordered by the physician.	G 165		
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on record review, staff interview, and patient interview, it was determined the agency failed to ensure verbal orders were put in writing for 2 of 12 patients (#10 and #11) whose records were reviewed. This had the potential to	G 166	All documentation of verbal orders to include date order was received • Nurse manager to educate staff regarding documentation of date verbal orders received. • Quality Consultant to do a daily audit of all verbal orders will determine inclusion of date order received. Audit indicators to be collected on 100% of physician orders. Audit to begin 5/20/13. Audit results to be at 90% compliance by 6/14/13	6/14/13

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G 166	Continued From page 21 negatively impact coordination and clarity of patient care. Findings include: 1. Patient #11 was an 81 year old female who was admitted to the agency on 2/14/13 for care primarily related to CHF. She also had diagnoses of hypertension and abnormality of gait. The certification period of 4/15/13 to 6/13/13 was reviewed. A "PT EVAL" visit note, dated 4/10/13 at 2:49 PM, stated physical therapy was to be continued "a few more weeks," but the medical record did not contain evidence the physician had been contacted for orders. Patient #11 had PT and PTA visits on 4/16/13, 4/18/13, 4/23/13, 4/25/13, and 5/02/13 without a physician's order. A "Case Communication Report," entered 4/14/13 at 5:53 PM by the RN Case Manager, stated "Phone call to Dr. [name] to review plan for homecare services. Plan for nursing to assess overall status,...PT to evaluate and treat. Treatment plan approved, orders obtained." There were no orders in the medical record to indicate verbal orders had been obtained. During an interview on 5/09/13 beginning at 11:30 AM, the RN Case Manager stated she had spoken with Patient #11's attending physician on Wednesday, 4/10/13 after the recertification visit had been completed. She stated she confirmed PT services would be needed, but had not obtained a frequency and duration. She stated the therapist would determine the frequency and duration.	G 166	5/14/13 - Staff educated regarding documentation for date verbal orders received. 5/20/13 – Audit began with a baseline of 80% compliance.	

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G 166	Continued From page 22 During an interview on 5/09/13 beginning at 1:15 PM, the Physical Therapist reviewed Patient #11's medical record and stated she had not remembered to obtain a physician's order for therapy services. Verbal orders were not documented for PT services. 2. Patient #10 was a 5 year old male admitted to the agency on 1/06/12 for SN services related to cystic fibrosis. The POC for the certification period 4/14/13 to 6/12/13, in Section 23, titled "Nurse's Signature and Date of Verbal SOC Where Applicable" the RN Case Manager's name was in printed form and dated 4/09/13. Below the printed entry of the case manager was her name and "Document Signed Electronically 4/16/13 5:02 PM". There was no written or signed verbal order in Patient #10's medical record dated 4/09/13. A "Case Communication Report," entered 4/14/13 at 1:50 AM by the RN Case Manager, stated "Phone call to Dr.[name] to review plan for homecare services. ...Treatment plan approved, orders obtained to recertify patient for services." It was not clear when the nurse spoke with the physician, when orders were obtained, or where the orders were. During an interview on 5/09/13 beginning at 11:20 AM, the RN Case Manager reviewed Patient #10's medical record and stated she had spoken with the physician on the date of recertification, which was 4/09/13. She stated she entered the "Case Communication Report" on 4/14/13, but did not write verbal orders.	G 166		

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G 166	Continued From page 23 Verbal orders were not documented for recertification of Patient #10.	G 166		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on review of medical records and staff interview it was determined the agency failed to ensure medical records clearly documented the course of treatment for 2 of 12 patients (#8 and #9) whose records were reviewed. The failure had the potential to result in incomplete information available to staff providing patient care. Findings include: 1. Patient #8 was a 90 year old female living in an ALF whose SOC was 4/10/13. Her diagnoses included insulin dependent diabetes. Her medical record for the certification period of 4/10/13 through 6/08/13 was reviewed. The "Agency Medication Profile" documented she was receiving two types of insulin via SQ injection. Lantus, a long acting insulin, was administered once daily in the morning. Humalog, a fast acting insulin, was given three times a day, at lunch dinner and bedtime, in accordance with a sliding	G 236	Treatment to be administered according to physician orders and documented consistently Nurse Manager to: • Educate staff regarding process of review of physician orders prior to providing care and documentation of administered medications to include: o Medication Name o Dose o Route o Site • A daily audit of any medications administered by home health nursing staff will determine if medications are administered according to physician's orders and if documentation includes medication name, dose, route, and site. Audit indicators to be collected on 100% of patients with medications administered by home health nursing staff. Audit to begin 5/20/13. Audit results to be at 90% compliance by 6/14/13.	6/14/13

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G 236	Continued From page 24 scale ordered by the physician. The amount of Humalog given correlated with Patient #8's blood sugar. The POC, signed by the physician 4/30/13, contained the same instructions, ordering SN staff to visit Patient #8 four times a day to administer insulin and assess diabetic status. Documentation of the administration of the insulin was unclear as follows: a. SN documented insulin had been administered but failed to document the type of insulin administered to Patient #8 on the following RN visit notes: - 4/11/13 at 12:00 PM - 4/13/13 at 4:45 PM - 4/14/13 at 11:45 AM, 4:30 PM, and 9:30 PM - 4/17/13 at 11:55 AM - 4/19/13 at 8:51 AM and 4:59 PM - 4/21/13 at 8:53 AM - 4/23/13 at 4:48 PM - 4/25/13 at 10:52 AM - 4/26/13 at 4:41 PM - 4/28/13 at 4:09 PM - 5/03/13 at 11:00 AM and 4:04 PM - 5/04/13 at 11:00 AM and 9:44 PM - 5/05/13 at 10:54 AM and 6:12 PM The Nurse Manager reviewed the record and was interviewed on 5/09/13 at 4:10 PM. She confirmed the documentation was unclear as to which type of insulin had been administered to Patient #8. She agreed it was important for SN staff to specify which type of insulin had been given as each insulin worked in a different way and could cause negative effects if administered at the wrong time.	G 236	5/14/13 - Staff educated regarding documentation of medication name, dose, route, and site when administering medications. 5/21/13 Begau daily medication audit for medications administered according to physician order and documentation to include medication name, dose, route, and site.	

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G 236	Continued From page 25 b. At approximately 1:05 PM on 5/09/13, the Quality Control Officer produced a reference document titled "Injections" from Mosby, Inc, copyright 2000. She stated that the agency used the procedures from this document as a protocol for staff when giving injections. The document stated that when repeated daily SQ injections are given, the injection site should be rotated. SN failed to document the site of the SQ insulin injections on the following RN visit notes: - 4/11/13 9:00 AM, 12:00 PM and 5:00 PM - 4/12/13 9:00 AM, 11:57 AM and 5:25 PM - 4/13/13 12:09 PM and 4:45 PM - 4/14/13 11:45 AM, 4:30 PM, 9:30 PM - 4/15/13 12:42 PM - 4/17/13 9:04 AM, 11:55 AM and 5:40 PM - 4/18/13 8:52 AM, 11:38 AM and 4:45 AM - 4/21/13 8:53 AM - 4/22/13 9:38 AM and 4:42 PM - 4/23/13 8:47 AM, 12:34 PM, and 4:48 PM - 4/24/13 8:36 AM and 9:40 PM - 4/25/13 8:57 AM and 10:52 AM - 4/26/13 8:46 AM and 4:41 PM - 4/27/13 9:04 AM, 12:13 PM and 4:27 PM - 4/28/13 8:57 AM, 11:24 AM and 4:09 PM - 4/29/13 9:13 AM, 12:17 PM and 4:50 PM - 4/30/13 11:52 AM - 5/01/13 9:30 PM - 5/02/13 9:00 AM and 10:42 AM - 5/03/13 11:00 AM and 6:04 PM - 5/04/13 11:00 AM and 9:44 PM - 5/05/13 9:10 AM, 10:54 AM and 4:12 PM - 5/06/13 8:49 AM The Nurse Manager reviewed the record and was interviewed on 5/09/13 at 4:10 PM. She	G 236		

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G 236	Continued From page 26	G 236		

confirmed the above RN visit notes did not document the sites of the insulin injections. She agreed that multiple nurses visited Patient #8 and it was difficult to ensure the site of the insulin injections were rotated per protocol if the site had not been documented.

c. An RN visit note from 4/11/13 at 9:00 AM documented Patient #8 had a BG of 92. The RN documented under "Home Monitoring Notes" 78 units of Lantus was administered and "24 units." There was no sliding scale Humalog ordered in the morning, it was unclear as to what "24 units" meant.

The RN that documented the note reviewed the record and was interviewed on 5/09/13 at 8:55 AM. She confirmed there was no sliding scale ordered in the morning for Humalog insulin. She stated she only gave Patient #8 the 78 units of Lantus. She could not explain why she documented "24 units." She agreed that this documentation lead to a lack of clarity as to whether Patient #8 received more insulin than had been ordered.

d. An RN visit note from 4/20/13 at 9:00 AM documented Patient #8's BG was 148. There was no documentation to indicate Lantus had been given during this morning visit. There was no documentation on the subsequent RN visit notes at 11:36 AM, 4:33 PM or 9:45 PM that Lantus had been given.

The RN who documented the RN visit note on 4/20/13 at 9:00 AM reviewed the record and was interviewed on 5/09/13 at 12:00 PM. She stated she had given Patient #8 Lantus that morning and

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G 236	Continued From page 27 had documented it in the medication log book at the ALF but confirmed she had not documented it in Patient #8's medical record. She agreed this lead to a lack of clarity as to the treatment of Patient #8's diabetes. e. An RN visit note from 4/27/13 at 4:27 PM documented Patient #8's BG was 130. According to the "Dinner scale" on the POC, Patient #8 should have received 24 units of Humalog insulin for a BG of 130. However, there was no documentation on the visit note to indicate Patient #8 received any insulin. The RN reviewed the record and was interviewed on 5/09/13 at 1:40 PM. She stated that she had given Patient #8 Humalog as ordered and had probably documented the amount of insulin given in the medication log book at the ALF. She confirmed she had not documented that insulin had been given in the medical record. She confirmed this lead to a lack of clarity as to whether Patient #8 received her insulin as ordered. Documentation of Patient #8's insulin was unclear. 2. Patient #9 was a 6 month old female who was admitted to the agency on 1/15/13 for SN services related to extreme prematurity and chromosomal abnormalities. The POC for the certification period 3/17/13 to 5/15/13 was reviewed. An "RN VISIT," dated 4/12/13 at 11:39 AM, documented Patient #9 had a pain level of 2, and required the use of pain medications 2-3 times	G 236		

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G 236	Continued From page 28 daily. There was no pain medication documented on the POC. During an interview on 5/09/13 beginning at 3:00 PM, the RN Case Manager reviewed Patient #9's medical record and confirmed the infant took no pain medications. She stated she did not know why she had documented that entry. She confirmed Patient #9's medical record was unclear as it related to pain medication. The documentation in Patient #9's medical record was unclear.	G 236		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on record review, policy review, observations during home visits, staff interview and patient interview, it was determined the agency failed to ensure the drug review was comprehensive for 5 of 12 patients (#2, #3, #5, #7 and #11) whose records were reviewed. Failure to obtain an accurate patient medication list or to evaluate the list for duplicative therapy, drug interactions, or significant side effects had the potential to place patients at risk for adverse events or negative drug interactions. Findings include: The agency policy titled "Horizon Medication	G 337	Medication lists to be reflective of current medications ordered by physician Nurse Manager to: • Educate staff regarding review of patient medications at every skilled visit and review of medications listed on the plan of care for accuracy at admission and recertification. Physician to be contacted as needed to reconcile medication discrepancies • Review of medication profile during interdisciplinary team meeting to begin 5/21/13. • An audit of the medication profile for accuracy will be done on 100% of patients discussed in weekly interdisciplinary team meeting. Audit to begin 5/21/13. Audit results to be at 90% compliance by 6/14/13.	6/14/13

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G 337	Continued From page 29 Check Homecare Procedure", dated August, 2011, included the following direction to the clinician: "Enter all medications including prescribed medications, herbal remedies, homeopathic products, and over-the-counter products into the patient record on admission. Update patient record with changes to the medications on recertification and when medication changes are made." A complete review of medications did not occur in the following examples: 1. Patient #5 was a 2 year old female who was admitted to the agency on 5/09/11 for skilled nursing services related to feeding problems and chromosomal abnormalities. The following medications were listed on Patient #5's POC for the certification period of 4/28/13 through 6/26/13: - Glycerin liquid, 0.5 ml as needed for constipation, - Miralax 17 gm/dose powder, 1/2 tsp oral as needed 1-2 times daily as needed to prevent constipation, - Antipyrine-benzocaine 5.4, 3-4 drops every 4 hours to ears as needed for pain, - Pediasure 1.5 with fiber, 1 as needed. On a SN home visit on 5/08/13 starting at 10:00 AM, surveyors completed a review of medications with Patient #5's mother. She stated she had not used the glycerin liquid or the ear drops for more than a year. In addition, she stated Patient #5 was taking children's gummy multivitamins. The gummy multivitamins were not included in Patient	G 337	• Audit for consistency of medication profile and medications listed on the plan of care by central audit team for 100% of admissions and recertification to begin 5/22/13. Audit results to be at 90% compliance by 6/14/13 • In home assessment of medication profile and medications being taken by patient during manager rounding to begin 5/21/13. Audit results to be at 90% compliance by 6/14/13. 5/14/13 - Staff educated regarding review of medications at every skilled visit, review of medications listed on the plan of care for accuracy at admission and recertification, and contacting physician to reconcile medication discrepancies 5/21/13 – Began review of medication profile during interdisciplinary team meetiug 5/21/13 – Began in home assessment of medication profile and medications being taken by patient during manager rounding 5/22/13 – Began central audit for consistency of medication profile and medications listed on the plan of care.	

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G 337	Continued From page 30 #5's medication profile and POC. During an interview on 5/09/13 at 3:00 PM the RN who provided care for Patient #5 reviewed the medical record. She stated she was unaware that Patient #5 was taking the multivitamins. She stated she was unaware Patient #5's mother had stopped the ear drops and glycerin liquid. She stated she did not review Patient #5's medications at each visit. The medication list and POC in Patient #5's medical record were not accurate and current on the date of the home visit. 2. Patient #11 was an 81 year old female admitted to the agency on 2/14/13 for SN and PT services related to CHF, HTN, and abnormality of gait. The following medications were listed on Patient #11's POC for the certification period of 4/15/13 through 6/13/13: -Amitriptyline 50 mg, 1 tablet at bedtime, -Tizanidine 4 mg, 1 capsule twice daily as needed for pain, -Lisinopril-Hydrochlorothiazide 20 mg-12.5 mg, 1 daily. An order in Patient #11's medical record, dated 4/03/13, indicated Patient #11's dosage of Lisinopril-Hydrochlorothiazide 20 mg-12.5 mg was increased from 1 tablet daily to 1 tablet twice daily. The POC had not been updated to include the new dosage. During an interview on 5/09/13 at 11:30 AM, the	G 337		

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G 337	Continued From page 31 RN Case Manager reviewed Patient #11's record and confirmed she had not updated the medications during the recertification visit on 4/10/13. She stated the computer software program would pre-populate the medications from the prior cert period, and the clinician would have to manually go back and enter the medication changes. The medication list and POC in Patient #11's medical record were not accurate and current on the date of the home visit. 3. Patient #3 was a 69 year old male admitted to the agency on 4/03/13 for wound care, catheter care, and physical therapy after a below the knee amputation to his left leg. A form titled "Agency Medication Profile," unsigned and undated, documented the medications Patient #3 was taking at the time of admission. It included: - Aspirin 325 mg orally, daily - Baclofen administer by intrathecal pump - Celebrex 200 mg orally, twice a day - Celexa 20 mg, orally, twice a day - Dantrolene Sodium 50 mg, orally, three times a day - Desonide lotion, applied to skin, twice a day - Gabapentin 300 mg, orally, three times a day - Hydrocodone/Acetaminophen 10 mg/325 mg, orally, every four hours as needed - Lisinopril/Hydrochlorothiazide 20 mg/12.5 mg, orally, twice a day - Nicotine Patch, one applied to skin daily - Pepcid 20 mg, orally, twice a day - Trazadone HCL 50 mg, orally, daily	G 337		

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G 337	Continued From page 32 Patient #3's POC for the certification period of 4/03/13 through 6/02/13 listed all of the above medication except for the Desonide lotion. During a PT visit on 5/07/13 beginning at 4:05 PM, a review of medications was completed with Patient #3's wife. She stated Patient #3 was no longer taking the Desonide lotion as the skin irritation it had been used for had cleared up. She stated Patient #3 was not taking Celebrex, Dantrolene, or Pepcid. She stated she was unfamiliar with these medications. The Physical Therapist who provided care for Patient #3 during this home visit was interviewed on 5/09/13 at 1:30 PM. She stated she was unaware Patient #3 was not taking Celebrex, Dantrolene or Pepcid and stated that she would confirm this with Patient #3's wife. She confirmed that the "Agency Medication Profile" and POC were inaccurate. The medication list and POC in Patient #3's medical record were not accurate and current on the date of the home visit. 4. Patient #7 was a 79 year old female admitted to the agency on 2/07/13 for treatment of asthma and emphysema. The certification period of 4/08/13 through 06/16/13 was reviewed. A form titled "Agency Medication Profile," unsigned and undated, documented the medications Patient #7 was taking during this certification period. It included: - Advair Diskus 100 mcg/50 mcg, inhaled once	G 337		

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G 337	Continued From page 33 daily - Albuterol 2.5 mg/ 3 ml, inhaled - Ambien 5 mg, orally, every night - Aspirin 81 mg, orally, daily - Brovana 15 mcg/2 ml inhaled daily - Imdur 60 mg, orally, daily - Lisinopril 20 mg, orally, daily - Lumagin eye drops, one drop in each eye - Milk of Magnesia, orally, as needed for constipation - Nitrostat 0.4 mg, under the tongue as needed for chest pain - Oxygen four liters per minute continuously - Pantoprazole 40 mg, orally, daily - Polyethylene Glycol, orally, as needed for constipation - Prednisone 10 mg, orally, four times a day - Singulair 10 mg tablet orally, daily - Tramadol 50 mg, half a tablet orally every four hours as needed for pain - Ventolin inhaled every four hours as needed for shortness of breath - Xanax 0.25 mg orally, every six hours as needed for anxiety Patient #7's POC listed all of the above medication except for the Imdur, Singulair, and Protonix. During an interview on 5/09/13 beginning at 10:55 AM, the Nurse Manager explained that the POC is just a "moment in time" of the patient plan of care and therefore did not always include all of the medications listed, as there may have been orders taken later for stopping or starting different medications. She stated the "Agency Medication Profile" was the most accurate list of medication as it was updated more frequently.	G 337		

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G 337	Continued From page 34 During a home visit to observe PTA services on 5/07/13, beginning at 12:00 PM, a review of medications was completed with Patient #7's daughter. Patient #7's daughter removed all of the bottles of medication from the cabinet where they were stored and reviewed each one with the surveyor and the Quality Control Officer, who was also present during the home visit. She stated Patient #7 was not using the Polyethylene glycol for constipation any longer, she had switched to magnesium citrate. She also stated that Patient #7 was not taking Imdur or Pantoprazole. She stated she had never heard of these medications before. During an interview on 5/09/13 beginning at 10:55 AM, the RN case manager confirmed that magnesium citrate was not on the "Agency Medication Profile." She stated she was unaware that Patient #7 was not taking Pantoprazole. She stated that Patient #7 had begun taking Imdur on 4/15/13 and that she should still be taking it. She could not explain why patient #7's daughter had never heard of this medication before. The medication list and POC in Patient #3's medical record were not accurate and current on the date of the home visit. 5. Patient #2 was an 88 year old male admitted to home health services 4/16/13 for SN, HHA and PT services following a recent hospitalization. His diagnoses included CKD, BPH, atrial fibrillation and abnormal gait. The following medications were listed on Patient #2's POC for the recertification period 04/16/13 to 06/14/13:	G 337		

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G 337	Continued From page 35 -Potassium Chloride 10 mEq ER 1 orally, daily -Flomax 0.4 mg SR 1 orally, daily -Potassium Chloride 10 mEq SA 2 orally, daily -Clobetasol Propionate 0.05% Ointment topical 2 times daily -Allopurinol 300 mg 1 orally, daily -Clotrimazole-Bethamethasone 1%-0.05% Cream topical 2 times daily -Metoprolol Tartrate 25 mg 1 orally, daily -Proscar 5 mg 1 orally, daily -Lanoxin 125 mcg 1 orally, every other day -Warfarin Sodium 5 mg half a tablet orally, every other day -Neosporin Combo PKG topical as needed for skin tears -Triamcinolone Acetonide 0.1% Cream 1 topical as needed for psoriasis -Tamsulosin HCL 0.4 mg ER 2 orally, daily -Neosporin 3.5 mg topical as needed daily to prevent infection -Aleve 220 mg 1 orally, as needed for sleep -Tolnaftate 1% Cream topical as needed twice daily for athletes foot On a SN home visit on 5/07/13 starting at 11:30 AM, surveyors completed a review of medications with Patient #2 and his wife. While reviewing medications, it was noted the bottle containing the Potassium Chloride 10 mEq ER was labeled with instructions to take four capsules daily. However, Patient #2 stated he only took two daily. Patient #2's wife then stated that he actually took one capsule daily. In an interview on 5/7/13 beginning at 4:30 PM, the RN case manager reviewed the medication list and confirmed medication reconciliation had	G 337		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137016	A. BUILDING _____ B. WING _____	05/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 337	Continued From page 36 not been done. She stated the medications had not been updated from the last certification period. The medications listed on Patient #2's POC were not accurate and current on the date of the home visit.	G 337		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001290	A. BUILDING: _____ B. WING _____	05/10/2013

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the state licensure survey of your home health agency. The surveyors conducting the survey were: Libby Doane, BSN, RN, HFS - Team Leader Susan Costa, RN, HFS Don Sylvester, RN, HFS	N 000		
N 155	03.07030. PLAN OF CARE N155 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: c. Types of services and equipment required; This Rule is not met as evidenced by: Refer to G159.	N 155	Refer to plan of correction for G159 RECEIVED JUN - 7 2013 FACILITY STANDARDS	
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	Refer to plan of correction for G164	
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs	N 173	Refer to plan of correction for G165, G166, G337	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001290	A. BUILDING: _____ B. WING _____	05/10/2013

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N 173	Continued From page 1 and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G165, G166 and G337.	N 173		
N 174	03.07031.01 CLINICAL RECORDS N174 01. Purpose. A clinical record containing past and current findings, in accordance with accepted professional standards, is maintained for every patient receiving home health services. This Rule is not met as evidenced by: Refer to G236.	N 174	Refer to plan of correction for G236	