IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
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Boise, ID 83720-0009
PHONE 208-334-6626
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July 7, 2014

Vicki Salerno, Administrator
Care At Home
929 NW 16th Street
Fruitland, ID 83619-2274

RE: Care At Home, Provider #137068

Dear Ms. Salerno:

This is to advise you of the findings of the complaint survey at Care At Home, which was concluded on June 12, 2014.

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

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

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

After you have completed your Plan of Correction, return the original to this office by **July 17, 2014**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626, option 4.

Sincerely,

Sylvia Creswell for

DON SYLVESTER
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

DS/pmt
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137068	A. BUILDING _____ B. WING _____	C 06/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE AT HOME	909 NW 16TH STREET, SUITE D FRUITLAND, ID 83619

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G 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation survey, completed 6/11/14-6/12/14, at your agency. The surveyors conducting the investigation were: Don Sylvester RN, BSN, HFS, Team Lead Nancy Bax, RN, BSN, HFS Acronyms used in this report include: COPD - Chronic Obstructive Pulmonary Disease DM - Diabetes Mellitus DON - Director of Nurses HHA - Home Health Aide HTN - hypertension OT - Occupational Therapy POC - Plan of Care PRN - as needed PT - Physical Therapy RN - Registered Nurse SN - Skilled Nurse SOC - Start of Care	G 000		
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 staff interview, it was determined the agency failed to ensure care followed a physicians written plan of care for 1 of 12 patients (#10) whose records were reviewed. This resulted in services being provided without a physician order and had the potential to result	G 158	**G158** **Action to be taken:** All clients will be evaluated upon admission for the need of bath aid services. Bath Aide care plan will be written upon admit. If client originally declines bath aid and then decides to utilize a bath aide the order and care plan will be written prior to scheduling aid. **Description of how action will improve the process:** This will ensure that the order is signed and that the care plan is in place for the bath aid to follow. Procedure for implementing: New scheduler took over June 1, 2014 and this is the procedure that she was taught and follows. **Completion date:** June 1, 2014 **Monitoring and tracking to ensure ongoing:** During the admission and OASIS chart review, the Chart Review RN will address the need for a bath aid based on the nurse assessment and written bath aid care plan. Chart Review RN will follow up with admitting RN if unclear. Scheduler will alert DNS or Chart Review RN as to the need for an order and care plan. **Title of person responsible for implementing POC:** Donna Forsyth Chart Review RN , April Saylors Scheduler, Kim Thomas DNS	

RECEIVED
JUL 16 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Vicki Salerno, Administrator

(X6) DATE
7.15.14

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

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G 158	Continued From page 1 negative patient outcomes. Findings include: 1. Patient #10's medical record documented a 73 year old male who was admitted for home health services on 3/08/14. His admitting diagnoses included obstructive chronic bronchitis, muscle weakness, dementia, coronary atherosclerosis, hypertension, and adjustment of urinary device. Patient #10's POC for the certification period 3/08/14 through 5/06/14, did not include an order for HHA services. Two HHA intervention notes dated 3/25/14 and 3/28/14, documented HHA services were rendered. Patient #10 and staff signed and dated the notes. The Director of Nursing was interviewed on 6/12/14 at 8:15 AM. She confirmed HHA services were completed without a physician's order. HHA services were provided to Patient #10 without a physician's order.	G 158	G224 **Action to be taken:** All nurses will do a complete review of the diagnosis upon admission, if there is a diagnosis that is an error it will be corrected with the MD at time of admission. **Description of how action will improve the process:** This will ensure that accuracy of the diagnosis for the purpose of coding and careplanning. **Procedure for implementation:** Admitting/ recertifying RN will review all diagnosis with the client upon admission/ recertification and compare to the MD's list of diagnosis. The Chart Review RN will also look at the diagnosis list along with the OASIS Assessment to assure they match and check that the Bath Aide care plan is appropriate. **Completion Date:** July 10, 2014. **Monitoring to ensure ongoing:** During the OASIS admission/ recertification chart review the Chart Review RN will assure the the diagnosis match the OASIS. The Bath Aide Care plan will be reviewed for accuracy also. **Title of Persons responsible for implementing:** RN Case Managers, Chart Review RN and Director of Nursing.	
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 nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the RNs prepared accurate and current written	G 224		

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G 224	Continued From page 2 patient care instructions for the HHA of 1 of 11 patients (#4) who were receiving aide services and whose records were reviewed. This resulted in an aide providing services that were not appropriate for the patient. Findings include: 1. Patient #4 was an 84 year old male admitted to the agency on 2/06/14, for care related to a urinary tract infection. Additional diagnoses included DM Type II, COPD and HTN. He received SN and HHA services from the agency. Patient #4's record included an HHA Care Plan, completed and signed by an RN on 2/06/14. The Care Plan included the following tasks: "Trim non-diabetic fingernails", and "Trim non-diabetic toenails". However, Patient #4's POC included a diagnosis of diabetes. The HHA visit notes dated 2/20/14 and 5/29/14, included "Non-diabetic toenails trimmed" as a completed task. During an interview on 6/12/14 at 9:20 AM, the DON stated the agency does not allow HHA's to trim nails on diabetic patients. She stated it was the agency's practice to make a note on the HHA Care Plan indicating a diagnosis of diabetes and instructing the HHA not to trim nails. The DON reviewed Patient #4's record and confirmed the HHA Care Plan should not include instructions to trim his nails. The HHA Care Plan created by the RN was not appropriate for Patient #4.	G 224		
G 225	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE	G 225		

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G 225	Continued From page 3 The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the HHA provided services in accordance with the POC for 1 of 11 patients (#1) who were receiving HHA services and whose records were reviewed. This had the potential to interfere with safety and quality of patient care. Findings include: 1. Patient #1 was an 85 year old male admitted to the agency on 5/21/14, for care related to acute kidney failure. Additional diagnoses included urine retention, HTN, and non-insulin dependent DM. He received SN, PT, OT and HHA services from the agency. Patient #1's record contained an HHA Care Plan, completed and signed by an RN on 5/21/14. His record also included 3 forms titled "Aide Intervention", dated 5/22/14, 5/27/14 and 5/30/14. The forms were completed and signed by a HHA. a. The HHA Care Plan indicated Patient #1 should receive a complete sponge bath during every HHA visit. - The "Aide Intervention" note dated 5/22/14, and signed by the HHA, indicated Patient #1 was given a tub bath. - Two "Aide Intervention" notes dated 5/27/14 and 5/30/14, and signed by the HHA, indicated Patient #1 was given a shower.	G 225	**G-225** **Action to be taken:** All clients recieving skilled bath aid services will be reviewed weekly to assure that the aides are following the careplans. Quality Control will generate a report that shows if the aides are following the care plan weekly. Any aide not following the care plan will be called in and educated immediately as to following what is written on the care plan. **Description of how action will improve the process:** This will ensure that the aides are following the care plans as written by the Case Managing RN. **Procedure to Implement:** Quality Control will beging following the bath aid supervisory visits to assure that all Aide interventions are checked. Quality Control will also generate the care plan reports to assure that the aides are following the care plans. **Completion Date:** July 15, 2014 **Monitoring and tracking to ensure ongoing:** Quality Control will alert the DNS as to aides that required further education. Weekly report will be given to DNS also after education provided. **Title of person responsible for implementing POC:** Kim Thomas DNS, Laura Dannenhold Quality Control.	

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G 225	Continued From page 4 b. Patient #1's HHA Care Plan also instructed the HHA to wash the skin around his catheter during every visit. - Three "Aide Intervention" notes, dated 5/22/14, 5/27/14 and 5/30/14, and signed by the HHA, did not document the HHA washed the skin around his catheter. Additionally, there was no documentation to indicate why the assigned task was not performed. During an interview on 6/12/14 at 9:30 AM, the DON reviewed Patient #1's record and confirmed the HHA did not complete the duties as assigned. The HHA did not provide services as ordered in the HHA Care Plan.	G 225		
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure home health aide supervisory visits were conducted every 14 days for 2 of 11 patients (#1 and #2) who received home health aide services and whose records were reviewed. This had the potential to interfere with the quality and safety of patient care. Findings include: 1. Patient #1 was an 85 year old male admitted to	G 229		

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G 229	Continued From page 5 the agency on 5/21/14, for care related to acute kidney failure. Additional diagnoses included urine retention, HTN, and non-insulin dependent DM. He received SN, PT, OT and HHA services from the agency. Patient #1's POC for the certification period 5/21/14 to 7/19/14, included orders for HHA visits 2 times a week. The first HHA visit was completed on 5/22/14. However, the first HHA supervisory visit was documented on 6/09/14, 18 days after the initial HHA visit. During an interview on 6/12/14 at 9:30 AM, the DON reviewed Patient #1's record and confirmed a HHA supervisory visit was not conducted within 14 days. The agency failed to ensure an HHA supervisory visit was completed within 14 days. 2. Patient #2 was a 96 year old male admitted to the agency on 1/09/14 for care related to chronic bronchitis. He received SN and HHA services from the agency. Patient #2 was discharged on 2/04/14. Patient #2's record included a POC for the certification period of 1/09/14 to 4/01/14. The POC included orders for HHA visits 1-2 times a week. The first HHA visit was completed on 1/10/14. However, the first HHA supervisory visit was documented on 1/27/14, 17 days after the initial HHA visit. During an interview on 6/12/14 at 9:15 AM, the DON reviewed Patient #2's record and confirmed a HHA supervisory visit was not conducted within 14 days.	G 229	**G 229** **Action to be taken:** All clients recieving bath aide services will be tracked by Quality Control upon initiating services on the Bath Aide Supervisory list. Nurses and therapist will be made aware of the need to start the supervisory visits and will be reminded at least 5 days before the visit is due. Visits will be turned in to Quality Control for tracking. List will be given to DNS weekly. **Description of how action will improve the process:** This will ensure that the visit is performed within 14 days of the last visit. **Procedure for Implementing:** Quality Control will assume the tracking list. Copy of Bath Aide Supervisory list will be kept on the computer with 1 hard copy available and printed weekly after updating. All nurses or therapists will be alerted by note or phone call as to the upcoming visits by the Quality Control Specialist. **Completion Date:** 7/14/14 **Monitoring and Tracking:** DNS will follow up with Quality Control once a week to assure the all Bath Aide clients are on the bath aide list. DNS will be aware of any upcoming visits needed with a hard copy list tp be printed once a week. **Title of person responsible for implementing the POC:** Kim Thomas DNS, Laura Dannenhold Quality Control.	

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G 229	Continued From page 6 The agency failed to ensure an HHA supervisory visit was completed within 14 days.	G 229		

Bureau of Facility Standards

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the complaint investigation survey, completed 6/11/14-6/12/14, at your agency. The surveyors conducting the investigation were: Don Sylvester RN, BSN, HFS, Team Lead Nancy Bax, RN, BSN, HFS Acronyms used in this report include: COPD - Chronic Obstructive Pulmonary Disease DM - Diabetes Mellitus DON - Director of Nurses HHA - Home Health Aide HTN - hypertension OT - Occupational Therapy POC - Plan of Care PRN - as needed PT - Physical Therapy RN - Registered Nurse SN - Skilled Nurse SOC - Start of Care	N 000	RECEIVED JUL 16 2014 FACILITY STANDARDS	
N 118	03.07024.SK.NSG.SERV. N118 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 Aide Registry. Duties of a home health aide include the following: h. Completing appropriate records. This Rule is not met as evidenced by: Based on staff interview and review of medical	N 118		

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Vicki Salerno, Administrator — 7.15.14

Bureau of Facility Standards

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N 118	Continued From page 1 records, it was determined the agency failed to ensure medical records were complete, accurate, and contained complete information for 4 of 12 patients (#3, #6, #9, and #11), whose records were reviewed. This resulted in in a lack of clarity as to the patients' care from agency personnel. Findings include: A form titled "Aide Intervention" was completed by the Agency's HHA's at every HHA visit. The form contained sections titled "VITAL SIGNS", "CARE PLAN ACTIVITIES", AND "CONCLUSION OF VISIT". The "CONCLUSION OF VISIT" section included areas for the HHA to document how the patient tolerated care, mental status changes, pain, skin breakdown, and changes in mobility and appetite. This section of the form was not consistently completed. Examples include: 1. Patient #3 was a 92 year old female, admitted to the agency on 3/25/14, with diagnoses of muscle weakness, hypertension and chronic kidney disease. Her medical record and POC for the certification period 3/25/14 through 5/23/14, were reviewed. "Aide Intervention" notes, dated 4/01/14, 4/04/14, 4/08/14, 4/11/14 and 4/28/14, did not have documentation of the "CONCLUSION OF VISIT" section complete. The Director of Nursing was interviewed on 6/12/14 at 8:15 AM. She confirmed Patient #3's, medical record included notes that lacked completion. 2. Patient #6 was a 90 year old female, admitted to the agency on 5/29/14, with diagnoses of muscle weakness, fistula of intestine, dementia and fitting and adjustment of urinary devices. Her	N 118	**N 118** **Action to be taken:** Care staff will be re-educated on need to conclude the visits with a written notice. As aide intervention sheets are turned in they will be reviewed for completeness by the biller prior to scanning into the computer. If intervention sheet is not complete aid will be called in to complete the conclusion of visit by the Scheduler. **Description of how the action will improve the process:** This will ensure the completeness of the aide interventions sheets and the conclusion of the visit. This will also allow for continuing education to the staff that will require it. **Procedure for implementing:** Aide interventions sheet will be visualised for completeness prior to scanning. If the visit is not completed the biller will alert the Scheduler and the aide will be called back to the office within one day to finish the visit. **Completion Date:** Inservice handed out with paychecks on 7/5/14 **Monitoring and Tracking to ensure ongoing:** DNS will follow up with biller once a week to ensure that checks are completed and to assess the number of staff that are not concluding the visit.	

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N 118	Continued From page 2 medical record and POC for the certification period 5/29/14 through 7/27/14, were reviewed. "Aide Intervention" notes, dated 5/30/14, did not have documentation of the "CONCLUSION OF VISIT" section complete. The Director of Nursing was interviewed on 6/12/14 at 8:15 AM. She confirmed Patient #6's, medical record included notes that lacked completion. 3. Patient #9 was an 88 year old female, admitted to the agency on 4/11/14, with diagnoses of atrial fibrillation, lumbago, restless leg syndrome and hypertension. Her medical record and POC for the certification period 4/11/14 through 6/09/14, were reviewed. "Aide Intervention" note, dated 4/17/14, did not have documentation of the "CONCLUSION OF VISIT" section complete and staff signature. The Director of Nursing was interviewed on 6/12/14 at 8:15 AM. She confirmed Patient #6's, medical record included notes that lacked completion. 4. Patient #11 was an 81 year old female, admitted to the agency on 3/02/13, with diagnoses of fitting and adjustment of urinary devices, muscle weakness, hypertension, history of transient ischemic attack and history of falls. Her medical record and POC for the certification periods 4/26/14 through 6/24/14, were reviewed. "Aide Intervention" notes, dated 4/15/14, 4/18/14, 4/22/14, 4/25/14, 4/29/14, 5/02/14, 5/06/14, 5/16/14, 5/20/14, 5/23/14, 5/27/14, 5/29/14, 6/03/14 and 6/06/14, did not have documentation	N 118		

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N 118	Continued From page 3 of the "CONCLUSION OF VISIT" section complete. The Director of Nursing was interviewed on 6/12/14 at 8:15 AM. She confirmed Patient #6's, medical record included notes that lacked completion. The agency did not ensure documentation for patient medical records was complete and accurate.	N 118		
N 119	03.07024.04.SK.NSG.SERV. N119 04. Supervisory Visits. A registered nurse or therapist makes a supervisory visit to the patient's residence at least every two (2) weeks, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are met. For patients who are receiving only home health aide services, a supervisory visit must be made at least every sixty (60) days. This Rule is not met as evidenced by: Refer to G229 as it relates to the failure of the agency to ensure aide supervisory visits were conducted at least every 2 weeks.	N 119	See POC for G-229	
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	N 122		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001080	A. BUILDING: _____ B. WING _____	C 06/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE AT HOME	909 NW 16TH STREET, SUITE D FRUITLAND, ID 83619

(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 122	Continued From page 4 exercises, are prepared by a registered nurse or therapist as appropriate. This Rule is not met as evidenced by: Refer to G224 as it pertains to the agency's failure to ensure appropriate written instructions were prepared for the home health aide.	N 122	See POC for G 224.	

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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July 21, 2014

Vicki Salerno, Administrator
Care At Home
929 Nw 16th Street
Fruitland, ID 83619-2274

RE: Care at Home, Provider #137068

Dear Ms. Salerno:

On **June 12, 2014,** a complaint survey was conducted at Care At Home. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006361

Allegation #1: Staff were not implementing appropriate infection control practices.

Findings #1: An unannounced survey of the home health agency was conducted 6/11/14 through 6/12/13. Twelve patients' records were reviewed; seven records for current patients and five records of discharged patients. Staff were interviewed.

One patient record reviewed described a 86 year old male who was admitted to the home health agency on 1/09/14 for care primarily related to obstructive chronic bronchiitis with acute exacerbation.

A "Care at Home" communication note dated 2/01/14, stated the OT reported the caregiver was not present during the visit. During the visit the OT warmed up some food for the patient. Several hours after the visit, the caregiver called the OT very irate, claiming that there was a dirty diaper and dishes in the sink. The OT documented, there was no diaper in the sink.

A "PT INTERVENTION", dated 2/02/14, stated, the caregiver was very angry concerning dirty diaper on the counter. The PT stated, she had forgotten about the diaper and she double bagged it, because she was so busy cleaning, feeding and conducting therapy for the patient. The PT stated, she apologized to the caregiver.

The Director of Nursing was interviewed on , 6/11/14 beginning at 8:15 AM. She confirmed the PT & OT notes of the issues with the caregiver. She stated the agency reported safety issues to Adult Protection Agency.

The other 11 patient records reviewed reflected appropriate infection control practices were adhered to.

It could not be determined through the investigative process that staff were not implementing appropriate infection control practices.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Staff did not protect patients' property.

Findings #2: An unannounced survey of the home health agency was conducted 6/11/14 through 6/12/13. Twelve patients' records were reviewed; seven records for current patients and five records of discharged patients. Staff were interviewed.

One patient record reviewed described a 96 year old male who was admitted to the home health agency on 1/09/14 for care primarily related to obstructive chronic bronchitis with acute exacerbation.

In a "Care at Home Communication Note", dated 1/31/14, the Home Health Aide indicated the patient was put on the toilet and and left him alone for a few minutes, when the Aide returned the patient had dropped his cell phone into the toilet." The Aide noticed this when the patient was transferred to the wheelchair. The Aide retrieved the phone and cleaned.

The Director of Nursing was interviewed on 6/11/14 beginning at 8:15 AM. She confirmed the Home Health Aide notes related to the cell phone in the toilet. She stated the agency was contacted by the caregiver in regards to the incident. The agency documented the phone conversation on 2/03/14 concerning the incident.

The other 11 patients' records reviewed reflected respect of each patient's property.

It could not be determined through the investigative process that staff misused patients property.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Staff behaved inappropriately when attempting to make a visit. This placed a patient at risk of a fall.

Findings #3: An unannounced survey of the home health agency was conducted 6/11/14 through 6/12/13. Twelve patients' records were reviewed; seven records for current patients and five records of discharged patients. Staff were interviewed.

One patient record reviewed described a 96 year old male who was admitted to the home health agency on 1/09/14 for care primarily related to obstructive chronic bronchitis with acute exacerbation.

A "Missed Visit Report", dated 1/17/14 at 1:00 PM, documented by an RN indicated the RN was unable to reach patient by phone and unable to get anyone to answer the door. It further noted the RN contacted the office scheduler to advise the scheduler of the missed visit while at the residence and that the RN had checked through windows to ensure client has not fallen inside the home. The missed visit report was signed by the physician on 1/20/14. The RN followed the agency's protocol for missed visits.

The Director of Nursing was interviewed on 6/11/14 beginning at 8:15 AM. She confirmed the missed visit report dated 1/17/14.

No concerns related to staff behavior were identified in the other 11 patients' records.

It could not be determined through the investigative process that staff acted inappropriately when attempting to make a scheduled visit.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

DONALD SYLVESTER
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

DS/pmt