



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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August 6, 2014

Sheryl Rickard, Administrator
Bonner General Hospital Home Health
520 North Third Avenue
Sandpoint, ID 83864

RE: Bonner General Hospital Home Health, Provider #137032

Dear Ms. Rickard:

This is to advise you of the findings of the Medicare/Licensure survey at Bonner General Hospital Home Health, which was concluded on July 23, 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.

Sheryl Rickard, Administrator
August 6, 2014
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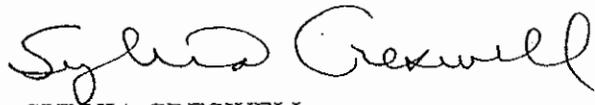
After you have completed your Plan of Correction, return the original to this office by August 19, 2014, and keep a copy for your records.

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

Sincerely,

Handwritten signature of Susan Costa in cursive, with the initials 'sc' written at the end of the signature.

SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care

Handwritten signature of Sylvia Creswell in cursive.

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pmt
Enclosures

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

PRINTED: 08/04/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER BONNER GENERAL HOSPITAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 602 NORTH THIRD AVENUE SANDPOINT, ID 83864	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification survey of your home health agency completed 7/21/14 - 7/23/14.</p> <p>The surveyors conducting the recertification were:</p> <p>Susan Costa RN, HFS, Team Lead Nancy Bax RN, BSN, HFS Laura Thompson, RN, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>BG - Blood Glucose BP - Blood Pressure CHF - Congestive Heart Failure CKD - Chronic Kidney Disease CNA - Certified Nurse Aide COPD - Chronic Obstructive Pulmonary Disease CPAP - Continuous Positive Airway Pressure ED - Emergency Department EMR - Electronic Medical Record DM II - Type 2 Diabetes Mellitus DME - Durable Medical Equipment HHA - Home Health Aide HTN - Hypertension Mg - milligrams MSW - Medical Social Worker NA - Not Applicable OT - Occupational Therapy POC - Plan of Care Pt - Patient PT - Physical Therapy RD - Registered Dietician RN - Registered Nurse ROC - Resumption of Care SN - Skilled Nursing</p>	G 000		

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FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sheryl L. Rickard TITLE: CEO (X6) DATE: 8/14/2014

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

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G 000	Continued From page 1 SOC - Start of Care TIF - Transfer to Inpatient Facility	G 000			
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on staff interview, policy review, and review of medical records, it was determined the agency failed to ensure care coordination between disciplines for 1 of 9 patients (#3) who received services from more than one discipline. This resulted in an unrecognized emergency medical condition and hospitalization of the patient. Findings include: Patient #3 was a 48 year old female admitted to the agency on 12/18/13, for SN, MSW, PT, and OT services related to difficulty walking, Type I diabetes, CKD, and encephalopathy related to poorly controlled diabetes. Patient #3's record and POC for the certification period 6/16/14 to 8/14/14 was reviewed. Patient #3's record included documentation by multiple care providers that she was not feeling well during the home health visits. Her physician and other disciplines were not notified of the findings, and on 2 occasions, she was hospitalized within days of the home health agency clinician visits. a. In an OT visit note, dated 6/18/14 at 1:05 PM,	G 143	Staff education specific to coordination of patient services completed on 8/14/14. (see exhibit A) Case conference policy (exhibit B) and process (exhibit C) has been updated to include patients with change in condition at any time during Agency provision of care. Standardized Clinical Guidelines / Reference for Physician Notifications policy was updated (see exhibit D). Comprehensive Assessment and Reassessment of Home Health patients was updated (see exhibit E). A minimum of 15 clinical records will be audited quarterly for compliance with this standard. This will be monitored by the Clinical Manager, or designee, with results forwarded to the Quality Manager. Additional education will be provided as needed based on audit findings.	08/14/14	

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G 143	<p>Continued From page 2</p> <p>the therapist documented Patient #3's blood glucose was above 550, and she self administered insulin. The therapist did not document how much insulin Patient #3 administered. The visit note did not include documentation the therapist communicated with Patient #3's physician or other disciplines of the elevated blood glucose result. Additionally, Patient #3's POC did not include individualized parameters for her blood glucose readings and when to notify her physician.</p> <p>The agency's policy, titled "Standardized Clinical Guidelines/Reference for Physician Notification", dated 1/18/10, stated "Clinician will establish parameters for blood glucose readings and instruct patient/family when to call MD. (Less than 80 or greater than 300, unless otherwise stated by MD.) Clinician and MD should also establish a target range for patients' blood glucose, and include this target within the patients' plan of care." This policy was not followed.</p> <p>b. In a SN visit note, dated 6/20/14 at 2:30 PM, the RN documented she performed a venipuncture for labwork that was ordered by Patient #3's physician. The RN did not indicate if a blood glucose reading was obtained at that time. There was no indication the nurse followed-up regarding the elevated blood glucose noted by the therapist 2 days before. The RN documented Patient #3's blood pressure was 88/48, with a pulse rate of 104. The nursing note did not include documentation she discussed her findings with other disciplines involved in Patient #3's care, or if the physician was notified of her low blood pressure or elevated pulse rate.</p>	G 143	

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G 143	<p>Continued From page 3</p> <p>c. An OT visit note dated 7/02/14 at 1:00 PM, documented Patient #3 had a large Band-Aid on her right anterior ankle. There was no further documentation to determine how the wound occurred, how long it had been there, or of the appearance of the wound. The therapist documented Patient #3 did not sleep well the night before, had the "sweats," and her thought process was slower than during the visit the week before. Additionally, the therapist documented Patient #3 required assistance with her wheelchair "likely due to hypotension." The therapist did not identify how she determined Patient #3 had hypotension. There was no documentation vital signs were obtained to confirm the blood pressure. The record did not include documentation of communication with Patient #3's physician, or other disciplines who provided her care, regarding the hypotension, slower thought processes, and right ankle wound.</p> <p>d. In a PT visit note later that day, 7/02/14 at 3:26 PM, the therapist noted Patient #3 was too fatigued for therapy exercises, and documented her gait was limited secondary to low blood pressure. There was no evidence in the physical therapist's note to indicate the occupational therapist communicated the concerns noted during the OT visit earlier that day. The physical therapist's note did not include documentation of Patient #3's vital signs, or how she determined Patient #3 had hypotension. There was no documentation the physical therapist notified Patient #3's physician about her fatigue and low blood pressure.</p> <p>e. In a PT visit note dated 7/03/14, Patient #3 was noted to have "...limited ambulation today secondary to low BP, requiring use of</p>	G 143		

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G 143	<p>Continued From page 4</p> <p>wheelchair." The therapist did not document a blood pressure reading, and did not describe how she determined Patient #3's blood pressure was low. Additionally, the therapist documented Patient #3 "feels like a limp rag," and experienced a dizzy episode that morning when getting out of bed. The visit note did not include documentation the physician or other members of Patient #3's home health team were notified of her findings.</p> <p>Patient #3's record included a TIF which documented she was hospitalized on 7/04/14. The transfer document indicated she was then emergently transported to a higher level of care facility and placed in intensive care. It noted her admitting diagnoses included blood glucose greater than 900, decreased level of consciousness, and dehydration.</p> <p>f. A ROC assessment was performed on 7/09/14 at 12:30 PM by an RN. The assessment documented Patient #3's blood glucose readings that day: 46, 116, 317, and 266. The record did not indicate the RN communicated Patient #3's abnormal blood glucose results to other members of her home health team.</p> <p>g. A PT resumption of care evaluation, dated 7/10/14, documented Patient #3 "reports discomfort and not feeling well, and reports of nausea." In the section of the evaluation "Care Coordination," the therapist wrote "SN, MSW," indicating she discussed Patient #3's plan of care with the Medical Social Worker and the RN, however, there was no documentation of what was discussed. There was no documented evidence that the therapist shared information about Patient #3's nausea and not feeling well with other team members or the physician.</p>	G 143		

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G 143	Continued From page 5 A TIF, completed 7/15/14, documented Patient #3 was admitted to the hospital on 7/12/14 for altered mentation, UTI, and neurological changes as noted on MRI. During an interview, on 7/23/14 beginning at 11:15 AM, the Agency Manager stated the Physical Therapist was on vacation and was unavailable to interview. The Agency Manager reviewed Patient #3's record and confirmed there was no documentation of communication between the members of Patient #3's home health care team. Care for Patient #3 was not coordinated to ensure all disciplines involved in her care were able to assess, identify, and communicate abnormal findings.	G 143		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on staff interview, and review of medical records, it was determined the agency failed to ensure care coordination between disciplines was documented for 1 of 9 patients (#11) who received services from more than one discipline and whose records were reviewed. This had the potential to interfere with quality and continuity of patient care. Findings include:	G 144	Staff education specific to coordination of patient services completed on 8/14/14 (see exhibit A) Case conference policy (exhibit B) and process (exhibit C) has been updated to include patients with change in condition at any time during Agency provision of provision of care. Standardized Clinical Guidelines / Reference for Physician Notifications policy was updated (see exhibit D) Comprehensive Assessment and Reassessment of Home Health patients was updated (see exhibit E). A minimum of 15 clinical records will be audited quarterly for compliance with this standard. This will be monitored by	08/14/14

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G 144	<p>Continued From page 6</p> <p>1. Patient #11 was a 71 year old female who was admitted to the agency on 6/10/14. The POC for the certification period 6/10/14 to 8/08/14 included SN, PT, OT, and HHA services related to CHF, HTN, and cellulitis of her left leg.</p> <p>A PT evaluation dated 6/18/14 at 12:00 PM, noted the POC was discussed with Patient #11, and in the section "Care Coordination," the therapist noted "Physician." The therapist did not include details of when the physician was contacted, or what the coordination activity included.</p> <p>During a PT visit on 7/17/14 beginning at 1:45 PM, the therapist noted Patient #11 complained of lightheadedness. The therapist documented she took Patient #11's blood pressure, and it was 104/54. The visit note did not include documentation of communication with the RN Case Manager or her physician regarding her blood pressure reading and lightheadedness.</p> <p>A SN visit note, dated 7/20/14 at 12:00 PM, included a blood pressure of 102/56. The RN visit note did not include evidence of communication with the physical therapist regarding Patient #11's lightheadedness during the PT visit 3 days earlier.</p> <p>In a phone interview on 7/23/14 at 10:40 AM, the RN Case Manager for Patient #11 reviewed her EMR and confirmed the lack of documentation of coordination of care. The RN stated she communicated frequently with both the physical and occupational therapists that worked with Patient #11, but did not document those activities in the medical record.</p>	G 144	<p>the Clinical Manager, or designee, with results forwarded to the Quality Manager.</p> <p>Additional education will be provided as as needed based on audit findings.</p>	

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G 144	Continued From page 7 Visit notes for Patient #11 from 6/10/14 to 7/21/14 were reviewed for documentation of coordination of care between the disciplines. There were 18 nursing visits, 9 physical therapy visits, and 4 occupational therapy visits. The visit notes did not include documentation of interdisciplinary care coordination.	G 144			
G 158	Coordination of care among personnel furnishing care to Patient #11 was not documented. 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, patient interview, and staff interview, it was determined the agency failed to ensure care followed a physician's written plan of care for 5 of 12 patients (#4, #6, #7, #10, and #11) 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 65 year old male admitted to the agency on 6/22/14, for SN, PT and HHA services related to COPD. Additional diagnoses included CKD, diabetes and CHF. a. Patient #6's record included a "Modified Order" written on 6/22/14 and signed by his physician on 6/24/14. Services were not provided as specified in the signed order, as follows:	G 158	Staff education specific to acceptance of patient's Plan of Care was completed on 8/14/14 (see exhibit A). Review of Physician Orders, Home Care Policy, and care process completed on 8/14/14. Physician licensing policy has been updated (see exhibit G). Agency will begin to transition care of patients who are unable to secure Idaho licensed physician to oversee Home Health Plan of Care with target completion for compliance by 9/30/14. Subsequent evaluations will be addressed at case conference to ensure completion and care coordination (see exhibit C). Agency will no longer accept patients to service who do not have a physician licensed to practice in the State of Idaho. A minimum of 15 clinical records will be audited quarterly for compliance with this standard. This will be monitored by the Clinical Manager, or designee, with results forwarded to the Quality Manager.	08/14/14 09/30/14	

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G 158	<p>Continued From page 8</p> <p>- An OT evaluation to be completed by the week of 6/30/14. Patient #6's record did not include documentation of an OT evaluation.</p> <p>-HHA visits were ordered once weekly for 5 weeks, effective the week of 6/22/14. The first and only HHA visit was documented 7/16/14. Patient #6's record included HHA missed visit documentation for 7/11/14 and 7/15/14. However, there were no HHA or missed visit documentation for the weeks of 6/22/14 or 6/29/14.</p> <p>-RD visits were ordered, effective 6/22/14, for 1-2 visits over the next 30 days. Patient #6's record did not include documentation of RD visits as of 7/23/14.</p> <p>-An MSW evaluation was ordered, to be completed by the week of 6/30/14. Patient #6's record did not include documentation of an MSW evaluation.</p> <p>A visit was made to Patient #6's home on 7/22/14 to observe a PT visit. During the visit Patient #6 was asked about the services he had received from the agency. He stated he was receiving SN and PT visits. Patient #6 stated the HHA had made one visit, the previous week. He also stated he had not had OT, RD or MSW visits.</p> <p>During an interview on 7/23/14 at 3:30 PM, the Agency Manager reviewed Patient #6's record and confirmed the orders for OT, HHA, RD and OT were not followed. She was unable to explain why the visits were not completed as ordered.</p> <p>Patient #6 did not receive OT, HHA, RD and OT visits as ordered by his physician.</p>	G 158	Additional education will be provided as needed based on audit findings.	

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G 158	<p>Continued From page 9</p> <p>2. Patient #5 was an 85 year old male admitted to the agency on 6/27/14, for SN and PT services related to a surgical wound. Additional diagnoses included cardiac dysrhythmia and generalized muscle weakness.</p> <p>a. Patient #5's record for the certification period 6/27/14 to 8/25/14, included a POC developed after the SOC assessment. It was signed on 7/01/14, by a physician who practiced and was licensed in another state. Patient #5's record also included "Modified Orders" dated 6/27/14, 6/30/14, 7/10/14, 7/11/14 and 7/17/14. The orders were also signed by the physician who practiced and was licensed in another state. The physician was not licensed in the state of Idaho.</p> <p>According to the definitions contained in the federal regulations for home health care at 42 CFR 484.4, "...a physician is a doctor of medicine, osteopathy or podiatry legally authorized to practice medicine and surgery by the State in which such function or action is performed."</p> <p>Because the attending physician was not licensed to practice in the state of Idaho, he did not meet the regulatory definition of physician.</p> <p>During an interview on 7/23/14 at 2:50 PM, the Agency Manager reviewed Patient #5's record and confirmed the POC and "Modified Orders" were signed by his physician in another state.</p> <p>Orders for Patient #5's care were not from a qualified physician who had an Idaho license and practiced in Idaho.</p>	G 158	

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G 158	<p>Continued From page 10</p> <p>b. Patient #5's POC for the certification period 6/27/14 to 8/25/14, included the following orders for wound care to his left lower leg, "Cleanse periwound area with wound cleanser...then apply antibiotic ointment and cover with clean dry gauze."</p> <p>SN visit notes, dated 6/27/14 and 6/30/14, documented Patient #5's surgical wound was cleansed with wound cleanser, covered with gauze, then wrapped with an ace wrap. However, his POC did not include ace wrap. Additionally, antibiotic ointment was not applied as ordered.</p> <p>During an interview on 7/23/14 at 10.:25 AM, the RN who performed Patient #5's wound care on 6/27/14 and 6/30/14, reviewed his record and confirmed the wound care provided did not follow the order on the POC. Additionally, she confirmed the ace wrap was not included on the POC.</p> <p>Patient #5's wound care was not performed as ordered on his POC.</p> <p>3. Patient #11 was a 71 year old female who was admitted to the agency on 6/10/14 for SN, PT, OT, and HHA services related to CHF, HTN, and cellulitis of her left leg. Her POC for the certification period 6/10/14 to 8/08/14 included daily weights with reports to her physician of weight gain.</p> <p>The SOC comprehensive assessment did not include Patient #11's weight. There were a total of 18 nursing visits, and Patient #11's weight was documented once, on 7/10/14, as 188 pounds.</p>	G 158		

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G 158	<p>Continued From page 11</p> <p>During a phone interview on 7/23/14 beginning at 10:40 AM, the RN Case Manager reviewed Patient #11's EMR and confirmed a weight was documented one time only. She stated Patient #11 was not stable to stand on a scale, and she was weighed once weekly when she went to the wound clinic. The RN confirmed she did not contact Patient #11's physician to update her POC and remove the daily weight order.</p> <p>Patient #11's POC was not followed.</p> <p>4. Patient #10 was a 58 year old male admitted to the agency on 6/16/10. His record and POC for the certification period 5/26/14 to 7/24/14, was reviewed. Additional diagnoses included chronic osteomyelitis and quadriplegia. He received SN services for care related to a pressure ulcer on his lower back.</p> <p>a. Patient #10's physician ordered specific wound care, with instructions that wound care be provided on Mondays and Fridays. Patient #10's POC was not followed as ordered by his physician. Examples include:</p> <p>-In week 4 of Patient #10's certification period, SN visits with wound care were documented on 6/18/14, a Wednesday, and 6/20/14, a Friday.</p> <p>-In week 6 of Patient #10's certification period, SN visits with wound care were provided on 6/30/14, a Monday, and 7/02/14, a Wednesday.</p> <p>During an interview on 7/23/14 at 3:00 PM, the Agency Manager reviewed Patient #10's record and confirmed the wound care was not consistently provided on Mondays and Fridays as</p>	G 158			

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G 158	<p>Continued From page 12 ordered.</p> <p>b. Patient #10's record included a SN visit note dated 7/07/14. The RN documented wound care included the application of antifungal cream. However, Patient #10's POC did not include an order for antifungal cream.</p> <p>During an interview on 7/23/14 at 3:00 PM, the Agency Manager reviewed Patient #10's record and confirmed there was no order for antifungal cream.</p> <p>Patient #10's wound care was not provided as ordered by his physician.</p> <p>5. Patient #4 was a 63 year old male admitted on 2/08/14 for SN, PT, and OT services related to an open wound of the elbow. Additional diagnoses include non-healing surgical wound, chronic pain, sleep disorder, DM Type II, HTN, depressive disorder, and abnormality of gait.</p> <p>The POC for the certification period 6/08/14 to 8/06/14 was reviewed. The following examples indicated the POC was not followed:</p> <p>a. The POC included SN visits three times weekly for six weeks. Patient #4 received nursing visits two times a week for four weeks. His record did not include evidence of missed visit reports for the weeks of 6/09/14, 6/16/14, 6/23/14, or 7/07/14, to indicate why two, instead of three visits were made.</p> <p>During an interview on 7/23/14 at 10:00 AM, the RN who provided care for Patient #4 reviewed his record and confirmed the SN visit frequency did</p>	G 158		

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G 158	Continued From page 13 not match the physician's orders. b. Patient #4's POC included 4-6 OT visits over 30 days, beginning 6/09/14. One visit was completed on 6/20/14. A missed visit report, dated 6/18/14 was documented, but the remaining 2-4 ordered visits were not accounted for. During an interview on 7/23/14 at 3:00 PM, the Agency Manager confirmed that Patient #4 received one OT visit in 30 days. She confirmed the frequency did not match the physician's orders.	G 158		
G 159	Patient #4's POC was not followed as ordered. 484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on review of patient records, agency policies, observation, and staff and patient interview, it was determined the agency failed to ensure POCs included all pertinent information, including diagnosis and nursing interventions, equipment, wound care instructions and all pertinent treatments for 9 of 12 patients (#1, #3,	G 159	Staff education specific to this standard was completed on 8/14/14 (see exhibit A) Standardized Clinical Guidelines / Reference for physician notification policy (exhibit D) was updated. Assessment/ Reassessment Agency policy was reviewed with staff on 8/14/14 (exhibit H) Review of 485 for completed orders, inclusion of all DME will now occur at weekly case conference (see exhibit C) A minimum of 15 clinical records will be audited quarterly for compliance with this standard. This will be monitored by the Clinical Manager, or designee, with results forwarded to the Quality Manager. Additional education will be provided as needed based on audit findings.	08/14/14

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G 159	<p>Continued From page 14</p> <p>#4, #5, #6, #8, #10, #11, and #12) whose records were reviewed. This had the potential to interfere with the thoroughness and consistency of patient care. Findings include:</p> <p>1. Patient #3 was a 48 year old female admitted to the agency on 12/18/13, for SN, PT, and OT services related to difficulty walking, Type I diabetes, CKD, and encephalopathy related to poorly controlled diabetes. Patient #3's record and POC for the certification period 6/16/14 to 8/14/14 were reviewed.</p> <p>a. In an OT visit note, dated 6/18/14 at 1:05 PM, the therapist documented Patient #3's blood glucose was above 550, and she self administered insulin. The therapist did not document how much insulin Patient #3 administered. Patient #3's POC did not include parameters for blood glucose readings and when to notify her physician.</p> <p>b. In a SN visit note, dated 6/20/14 at 2:30 PM, the RN documented she performed a venipuncture for labwork ordered by Patient #3's physician. The RN did not indicate if a blood glucose reading was obtained at that time. The RN documented Patient #3's blood pressure as 88/48, with a pulse rate of 104. The nursing note included a section titled "Med safety measures," and the nurse documented "Emerg (emergency) plan for s/s (signs symptoms) hypo/hyperglycemia." Patient #3's POC did not include parameters for blood pressure, pulse, or blood glucose ranges. Additionally her POC did not include patient education interventions which described what hypo or hyperglycemia was, or when her physician was to be notified.</p>	G 159		

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G 159	<p>Continued From page 15</p> <p>c. A ROC assessment was performed on 7/09/14 at 12:30 PM by an RN. The assessment documented Patient #3's blood glucose readings that day as 46, 116, 317, and 266. The POC did not include parameters for glucose readings and when her physician was to be notified.</p> <p>The agency's policy, titled "Standardized Clinical Guidelines/Reference for Physician Notification", dated 1/18/2010, stated "Clinician will establish parameters for blood glucose readings and instruct patient/family when to call MD. (Less than 80 or greater than 300, unless otherwise stated by MD.) Clinician and MD should also establish a target range for patients' blood glucose, and include this target within the patients' plan of care." Patient #3's POC did not include blood glucose parameters as required by the agency's policy.</p> <p>During an interview on 7/23/14 beginning at 11:15 AM, the Agency Manager reviewed Patient #3's record and confirmed that Patient #3's POC did not have established parameters for blood pressure, pulse, or glucose, or direction of when Patient #3's physician should be notified.</p> <p>2. Patient #6 was a 65 year old male admitted to the agency on 6/22/14, for SN, PT and HHA services related to COPD. Additional diagnoses included chronic kidney disease, diabetes and CHF.</p> <p>a. Patient #6's record included a SN visit note, dated 6/24/14, and signed by the RN. The note documented a blood glucose level of 344. There was no documentation to indicate his physician</p>	G 159		

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G 159	<p>Continued From page 16</p> <p>was notified of his elevated blood glucose level.</p> <p>Patient #6's POC did not include a target range for blood glucose readings, or orders to instruct him and his family on when to call the physician regarding blood glucose results.</p> <p>The agency's policy, titled "Standardized Clinical Guidelines/Reference for Physician Notification", dated 1/18/2010, stated "Clinician will establish parameters for blood glucose readings and instruct patient/family when to call MD. (Less than 80 or greater than 300, unless otherwise stated by MD.) Clinician and MD should also establish a target range for patients' blood glucose, and include this target within the patients' plan of care." Patient #6's POC did not include blood glucose parameters as required by the agency's policy.</p> <p>During an interview on 7/23/14 at 3:30 PM, the Agency Manager reviewed Patient #6's record and confirmed his POC should have included a target range for blood glucose results, including guidelines on when to notify his physician.</p> <p>b. A visit was made to Patient #6's home on 7/22/04 at 9:00 AM, to observe a PT visit. During the visit, the physical therapist assisted him to ambulate from his bedroom to the car. Patient #6 stated he needed to rest before walking back into the house, due to back pain.</p> <p>After returning to his bedroom, the physical therapist talked to Patient #6 about the goals that were established at his SOC. One of his goals was to ambulate 200 feet. She told Patient #6 the distance to the car and back was</p>	G 159			

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G 159	<p>Continued From page 17</p> <p>approximately 75 feet. She stated she felt 200 feet was not a reasonable goal because the level of pain in his back was limiting him from ambulating more than 75 feet. Patient #6's POC did not include a diagnosis or interventions related to back pain.</p> <p>During an interview on 7/23/14 at 8:00 AM, the Physical Therapist was asked what caused Patient #6's back pain. She stated she did not know, but thought it was long standing. She confirmed Patient #6's POC did not include interventions to address his back pain.</p> <p>3. Patient #11 was a 71 year old female who was admitted to the agency on 6/10/14 for SN, PT, OT, and HHA services related to CHF, HTN, and cellulitis of her left leg. Her POC for the certification period 6/10/14 to 8/08/14 did not include the following:</p> <p>Patient #11's POC included an oxygen concentrator, however, the medication section did not include oxygen, method of delivery, or liter flow amount. Her medical record included an ED visit note that documented she was on CPAP and oxygen at night and during naps. The POC did not include a CPAP. The SOC assessment, dated 6/10/14, noted Patient #11 was on oxygen at 3 liters per minute by nasal cannula at night and naps. However, this information was not found on Patient #11's POC.</p> <p>During a telephone interview on 7/23/14 at 10:40 AM, the RN Case Manager reviewed Patient #11's EMR. She confirmed Patient #11 required oxygen and use of a CPAP for naps and at night, and these was not included on the POC.</p>	G 159		

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G 159	<p>Continued From page 18</p> <p>4. Patient #12 was a 75 year old male who was admitted to the agency on 1/07/14 for PT services related to a torn ligament in his left shoulder. Additional diagnoses included multiple sclerosis, HTN, chronic DVT, and long term use of anticoagulants. Patient #12's POC for the certification period 7/06/14 to 9/03/14 was reviewed.</p> <p>DME included on his POC listed "alcohol swabs." On 7/22/14 at 3:00 PM, during a visit to Patient #12's home to observe the physical therapist providing care, additional DME and supplies were noted that were not included on his POC:</p> <ul style="list-style-type: none"> - Upon entry into Patient #12's home, he was noted to be sitting on a motorized scooter. - A specialized walker was in the room. Patient #12's wife demonstrated how it was used. - A set of parallel bars was noted in the living room, and Patient #12's wife stated he used them daily for upper body strengthening. - Patient #12 rode upstairs by means of a motorized chair-lift device that was mounted on one wall along the stairwell. - In his room upstairs, Patient #12 was noted to have a trapeze over his bed. - Patient #12's wife stated he used a condom catheter at night. - His wife stated that frequently the physical therapist will apply kinesiotape to Patient #12's left arm and shoulder. 	G 159		

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G 159	<p>Continued From page 19</p> <p>During an interview on 7/23/14 beginning at 1:00 PM, the Agency Manager reviewed Patient #12's record and confirmed his POC did not include the DME and supplies noted during the home visit.</p> <p>Patient #12's POC did not include all pertinent information.</p> <p>5. Patient #1 was a 100 year old female admitted to the agency on 7/01/14, for SN, HHA and MSW services related to dementia. Additional diagnoses included depressive disorder and hypertension. Patient #1's record and POC for the certification period 7/01/14 to 8/30/14 were reviewed.</p> <p>Patient #1's medical record contained documentation from her physician's office, which included a list of her medications. The medication list indicated her physician prescribed Zoloft (an antidepressant medication) on 6/06/14, and the Zoloft was discontinued on 6/12/14 because she developed a rash. However, Patient #1's POC did not list Zoloft as an allergy.</p> <p>During an interview on 7/23/14, the RN who created the POC reviewed Patient #1's record and confirmed her allergy to Zoloft should have been included on the POC.</p> <p>Patient #1's POC did not include all of her allergies.</p> <p>6. Patient #5 was an 85 year old man admitted to the agency on 6/27/14, for SN and PT services related to a surgical wound. Additional diagnoses included cardiac dysrhythmia and generalized muscle weakness. His record and POC for the certification period 6/27/14 to 8/25/14 were</p>	G 159		

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G 159	<p>Continued From page 20 reviewed.</p> <p>The RN who performed Patient #5's SOC comprehensive assessment on 6/27/14, documented wound care included non-stick gauze and an ace wrap. The assessment also indicated Patient #5 used a walker to ambulate. A PT visit note completed on 7/08/14, also documented Patient #5 used a walker to ambulate. However, the POC did not include wound care supplies, a walker or cane.</p> <p>During an interview on 7/23/14 at 10:25 AM, the RN who performed Patient #5's SOC assessment and developed the POC, reviewed his record and confirmed the wound care supplies, walker and cane should have been included on the POC.</p> <p>Patient #5's POC did not include the equipment and supplies he was using.</p> <p>7. Patient #8 was an 82 year old female admitted to the agency on 7/17/14 for PT services after a fall in which she broke her left arm. Her record and POC for the certification period 7/17/14 to 9/14/14 were reviewed.</p> <p>The section at locator #14, "DME and Supplies," had the letters "N/A," indicating "not applicable." However, during the 7/17/14 SOC comprehensive assessment, the physical therapist noted Patient #8 was using a cane, a quad cane, and her left arm was in a sling.</p> <p>During an interview on 7/23/14 beginning at 8:00 AM, the Physical Therapist who performed the SOC assessment, reviewed Patient #8's record and confirmed she did not include the DME and sling on the POC.</p>	G 159			

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G 159	Continued From page 21 Patient #8's POC did not include all pertinent information. 8. Patient #10 was a 58 year old male admitted to the agency on 6/16/10. Patient #10's diagnoses included chronic osteomyelitis and quadriplegia. His record and POC for the certification period 5/26/14 to 7/24/14, was reviewed, and included SN services for care related to a pressure ulcer on his lower back. Patient #10's POC was not comprehensive. Examples include: a. Patient #10's POC included orders for wound care to his left hip wound, however, it did not state how often the wound care was to be completed. b. Patient #10's POC contained goals stating patient would be able to verbalize understanding of wound healing, pressure relief, nutritional support and fluid retention. However, the POC did not include interventions to educate Patient #10 in these areas. c. In a SN visit note dated 5/28/14, the RN documented Patient #10 used a wheelchair, however, the wheelchair was not included on the POC. During an interview on 7/23/14 at 3:00 PM, the Agency Manager reviewed Patient #10's record and confirmed the POC did not include frequency of wound care, patient education or his wheelchair. Patient #10's POC was not comprehensive to	G 159	Specific to finding #8, (see exhibit 1) pressure ulcer is patient's primary diagnosis, secondary diagnosis detail additional diagnosis specific to Plan of of Care as well.	5/26/14	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137032	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER BONNER GENERAL HOSPITAL HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 602 NORTH THIRD AVENUE SANDPOINT, ID 83864		
(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 159	Continued From page 22 include all of his needs. 9. Patient #4 was a 63 year old male admitted on 2/08/14 for SN, PT, and OT services related to open wound of the elbow. Additional diagnoses include non-healing surgical wound, chronic pain, sleep disorder, DM Type II, HTN, depressive disorder, and abnormality of gait. Patient #4's record and POC for the certification period 6/08/14 to 8/06/14, was reviewed and did not include the following DME: A visit to Patient #4's home to observe care provided by the RN was conducted on 7/23/14, beginning at 9:00 AM. He was noted to be using a hospital bed with trapeze, walker, and a speciality air mattress, however, they were not included on his POC. During an interview on 7/23/14 beginning at 10:00 AM, the RN who provided care to Patient #4 confirmed the walker, hospital bed, trapeze, and speciality mattress was not included as DME on the POC.	G 159		
G 164	Patient #4's POC did not include all his DME. 484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on review of patient records, agency policies, and staff interview, it was determined the	G 164	Staff education specific to periodic review of Plan of Care was completed on 8/14/14 (see exhibit A). Standardized Clinical Guidelines / Reference for physician notification was updated (see exhibit D). 485 will be reviewed at case conference to ensure parameters are identified when appropriate for physician notification (see exhibit C)	

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G 164	<p>Continued From page 23</p> <p>agency staff failed to alert the physician to changes that suggested a need to alter the plan of care in 4 of 12 patients (#3, #6, #9, and #10) whose records were reviewed. This resulted in delayed medical care culminating in an emergency medical condition and hospitalization. Findings include:</p> <p>1. Patient #3 was a 48 year old female admitted to the agency on 12/18/13, for SN, PT, and OT services related to difficulty walking, Type I diabetes, CKD, and encephalopathy related to poorly controlled diabetes. Patient #3's record and POC for the certification period 6/16/14 to 8/14/14 was reviewed.</p> <p>Patient #3's record included documentation by multiple care providers that she was not feeling well during the visits, her physician was not notified of their findings, and within days required hospitalization as follows:</p> <p>a. In an OT visit note, dated 6/18/14 at 1:05 PM, the therapist documented Patient #3's blood glucose was above 550, and she self administered insulin. The therapist did not document how much insulin Patient #3 administered. Patient #3's POC did not include parameters for blood glucose readings and when to notify her physician. The visit note did not include documentation Patient #3's physician was notified of the elevated blood glucose result.</p> <p>The agency's policy, titled "Standardized Clinical Guidelines/Reference for Physician Notification", dated 1/18/2010, stated "Clinician will establish parameters for blood glucose readings and instruct patient/family when to call MD. (Less than 80 or greater than 300, unless otherwise</p>	G 164	<p>A minimum of 15 clinical records will be audited quarterly for compliance with this standard. This will be monitored by the Clinical Manager, or designee, with results forwarded to the Quality Manager.</p> <p>Additional education will be provided as needed based on audit findings.</p>	

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G 164	<p>Continued From page 24</p> <p>stated by MD.) Clinician and MD should also establish a target range for patients' blood glucose, and include this target within the patients' plan of care." Patient #3's physician was not notified of her blood glucose reading of above 300.</p> <p>b. In a SN visit note, dated 6/20/14 at 2:30 PM, the RN documented she performed a venipuncture for labwork ordered by Patient #3's physician. The RN did not indicate if a blood glucose reading was obtained at that time. The RN documented Patient #3's blood pressure as 88/48, with a pulse rate of 104. The nursing note included a section titled "Med safety measures," and the nurse documented "Emerg (emergency) plan for s/s (signs symptoms) hypo/hyperglycemia." Patient #3's POC did not include parameters for blood pressure or blood glucose ranges. Additionally her POC did not include patient education interventions which described what hypo or hyperglycemia was, or when her physician was to be notified. The visit note did not include documentation Patient #3's physician was notified of her low blood pressure or elevated pulse rate.</p> <p>The agency's policy, titled "Standardized Clinical Guidelines/Reference for Physician Notification", dated 1/18/2010, stated "Clinician will notify the Physician of a BP of 200/100 (with or without symptoms), or any symptoms of hyper or hypotension (new onset falls, marked dizziness, severe headache, blurred vision) should result in immediate consultation with physician or immediate medical attention." The policy did not identify parameters for hypotension.</p> <p>c. An OT visit note dated 7/02/14 at 1:00 PM,</p>	G 164	

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G 164	<p>Continued From page 25</p> <p>documented Patient #3 had a large Band-Aid on her right anterior ankle. There was no further documentation to determine how the wound occurred, how long it had been there, or of the appearance of the wound. The therapist documented Patient #3 did not sleep well the night before, had the "sweats," and her thought process was slower than the visit the week before. Additionally, the therapist documented Patient #3 required assistance with her wheelchair "likely due to hypotension." There was no documentation vital signs had been obtained, and the therapist did not identify how she determined Patient #3 had hypotension. The record did not include documentation Patient #3's physician was notified of her hypotension, slower thought processes, and right ankle wound.</p> <p>d. A PT visit note later that day, 7/02/14 at 3:26 PM, the therapist noted Patient #3 was too fatigued for therapy exercises, and documented her gait was limited secondary to low blood pressure. The therapist did not indicate she obtained vital signs, or how she determined Patient #3 had hypotension. There was no documentation the therapist notified Patient #3's physician about her fatigue and low blood pressure.</p> <p>e. In a PT visit note dated 7/03/14, Patient #3 was noted to have "...limited ambulation today secondary to low BP, requiring use of wheelchair." The therapist did not document a blood pressure reading, and did not describe how she determined Patient #3's blood pressure was low. Additionally, the therapist documented Patient #3 "feels like a limp rag," and experienced a dizzy episode that morning when getting out of bed. The visit note did not include documentation</p>	G 164		

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G 164	<p>Continued From page 26</p> <p>Patient #3's physician was notified of her findings.</p> <p>Patient #3's record included a TIF, which documented she went to a local hospital on 7/04/14. It stated she was then emergently transported to a higher level of care facility and placed in intensive care, for blood glucose greater than 900, decreased level of consciousness, and dehydration.</p> <p>f. A ROC was performed on 7/09/14 at 12:30 PM by an RN. The assessment documented Patient #3's blood glucose readings that day: 46, 116, 317, and 266. The record did not indicate Patient #3's physician was contacted for resumption of care orders or to notify the physician of the wide range of blood glucose readings.</p> <p>g. A PT resumption of care evaluation, dated 7/10/14, documented Patient #3 "reports discomfort and not feeling well, and reports of nausea." The section of the evaluation "Care Coordination," the therapist wrote "SN, MSW," indicating she discussed Patient #3's plan of care with the Medical Social Worker and the RN. There was no documentation Patient #3's physician was advised that she did not feel well.</p> <p>A TIF, completed 7/15/14, documented Patient #3 was admitted to the hospital on 7/12/14 for altered mentation, UTI, and neurological changes as noted on MRI.</p> <p>During an interview, on 7/23/14 beginning at 11:15 AM, the Agency Manager stated the Physical Therapist was on vacation and was unable to interview. The Manager reviewed Patient #3's record and confirmed there was no documentation of physician notification in the</p>	G 164			

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G 164	<p>Continued From page 27</p> <p>above examples. She confirmed that Patient #3's POC did not have established parameters for blood pressure, pulse, or glucose for direction of when to notify Patient #3's physician.</p> <p>Patient #3's physician was not notified of abnormal findings.</p> <p>2. Patient #6 was a 65 year old man admitted to the agency on 6/22/14, for SN, PT and HHA services related to COPD. Additional diagnoses included chronic kidney disease, diabetes and CHF. His record and POC for the certification period 6/22/14 to 8/20/14, were reviewed.</p> <p>Patient #6's record included a SN visit note, dated 6/24/14, and signed by the RN. The note documented a blood glucose level of 344. There was no documentation to indicate his physician was notified of his elevated blood glucose level.</p> <p>The agency's policy, titled "Standardized Clinical Guidelines/Reference for Physician Notification", dated 1/18/2010, states "Clinician will establish parameters for blood glucose readings and instruct patient/family when to call MD. (Less 80 or greater than 300, unless otherwise stated by MD). Clinician and MD should also establish a target range for patients' blood glucose, and include this target within the patients' plan of care."</p> <p>Patient #6's POC did not include a target range for blood glucose readings, or orders to instruct him and his family on when to call the physician regarding blood glucose results.</p> <p>During an interview on 7/23/14 at 3:30 PM, the</p>	G 164		

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G 164	<p>Continued From page 28</p> <p>Agency Manager reviewed Patient #6's record and confirmed the physician was not notified of his elevated blood glucose level. Additionally, she confirmed according to agency policy, the physician should have been notified, and Patient #6's POC should have included a target range for blood glucose results.</p> <p>Patient #6's physician was not notified of his elevated blood glucose level.</p> <p>3. Patient #10 was a 58 year old man admitted to the agency on 6/16/10. His record for the certification period 5/26/14 to 7/24/14, was reviewed. He received SN services for care related to a pressure ulcer on his lower back. Additional diagnoses included chronic osteomyelitis and quadriplegia.</p> <p>Patient #10's record included SN visit notes for 5 consecutive visits that documented elevated blood pressure readings, as follows:</p> <p>7/02/14 - 140/92 7/07/14 - 160/100 7/11/14 - 180/100 7/14/14 - 160/98 7/16/14 - 172/100</p> <p>There was no documentation to indicate Patient #10's physician was notified of his elevated blood pressure readings.</p> <p>The agency's policy, titled "Standardized Clinical Guidelines/Reference for Physician Notification", dated 1/18/2010, states "If on three consecutive readings, a BP is greater than 140/90, but less than 200/105, consult with MD to establish BP target range and alarm values individualized to</p>	G 164	

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G 164	<p>Continued From page 29 patient."</p> <p>During an interview on 7/23/14 at 3:00 PM, the Agency Manager reviewed Patient #10's record and confirmed his physician was not notified of his elevated blood pressure readings. Additionally, she confirmed according to agency policy, the physician should have been notified.</p> <p>Patient #10's physician was not notified of his elevated blood pressure readings.</p> <p>4. Patient #9 was an 88 year old female, admitted on 7/08/2014, for SN services related to pressure ulcer. Additional diagnoses include pressure ulcer stage IV, DM Type II, nerve damage of extremities, CKD Stage III. Patient #9's record and POC, for the certification period 7/08/14 to 9/05/14, were reviewed.</p> <p>An RN visit note dated 7/18/14 at 10:00 AM, included documentation the RN was unable to feel Patient #9's pedal pulse, and she did not specify whether it was not felt in one specific foot or both feet. She noted the capillary refill time as greater than 3 seconds, which indicated decreased blood supply and perfusion of that extremity. The EMR software for the visit note included a section "Plan of Care Discussed With," that documented she spoke with the family, caregiver, primary nurse, and interdisciplinary team, indicating Patient #9's physician was not notified of the abnormal findings.</p> <p>During an interview on 7/23/14 at 10:00 AM, the RN who provided care to Patient #9 on 7/18/14, reviewed the EMR and confirmed she did not notify the physician. She stated she did not</p>	G 164		

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G 164	Continued From page 30 consider her findings to be abnormal, as Patient #9 had edema of that extremity, and considering her disease process, she would not be able to palpate the pulse.	G 164			
G 224	Patient #9's physician was not informed of abnormal findings during an assessment. 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 HHA provided services in accordance with the HHA care plan drafted by the RN, for 1 of 3 sample patients (#11) who received aide services. Failure of the aide to follow the care plan had the potential to negatively impact the quality of patient care. Findings include: Patient #11 was a 71 year old female who was admitted to the agency on 6/10/14 for SN, PT, OT, and HHA services related to CHF, HTN, and cellulitis of her left leg. Her POC for the certification period 6/10/14 to 8/08/14 included HHA visits 1-2 times weekly for 5 weeks. The HHA care plan in Patient #11's record, was developed by the RN Case Manager. The care plan included vital sign parameters, bathing instructions, skin care, bathroom cleaning, light	G 224	Staff education specific to assignment and duties of Home Health Aide completed on 8/13/14 and 8/14/14 (see exhibits A, J, K) Home Health Aide will perform weekly audits of 100% of documentation to ensure Plan of Care followed, until compliance met, then a minimum of 15 clinical records will be audited quarterly for compliance with this standard. This will be monitored by the Clinical Manager, or designee, with results forwarded to the Quality Manager. Additional education will be provided as needed based on audit findings.	08/14/14 08/14/14	

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G 224	<p>Continued From page 31</p> <p>housekeeping, changing bed linens and making the bed. Additionally, the HHA care plan included special instructions to cover Patient #11's leg wound dressing with a plastic bag to keep the dressing dry when bathing. The HHA did not provide care for Patient #11 in accordance to the care plan as follows:</p> <ul style="list-style-type: none"> - 6/18/14 at 12:40 AM, vital signs were not done. There was no documentation the wound dressing was covered to keep it dry. Additionally, there was no documentation bed linens were changed or the bed was made. - 6/27/14 at 12:20 PM, vital signs were not done. There was no documentation the leg wound dressing was covered to keep it dry during bathing. - 7/01/14 at 1:10 PM, vital signs were not done. There was no documentation the wound dressing was covered to keep it dry during bathing. There was no documentation bed linens were changed or the bed was made. - 7/11/14 at 12:15 PM, vital signs were not done. The CNA documented Patient #11 refused her bath and shampoo. There was no documentation bed linens were changed, or the bed was made. She documented "Patient had just come home from wound care and requested that I assist her in preparing her meal, I did assist." Meal preparation was not included in the HHA care plan. - 7/18/14 at 1:45 PM, vital signs were not documented. There was no documentation bed linens were changed or the bed was made. 	G 224		

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G 224	Continued From page 32 During a phone interview on 7/23/14 beginning at 10:40 AM, the RN Case Manager stated the HHA care plan included vital sign parameters so she would expect the HHA to obtain Patient #11's vital signs with each visit. The RN Case Manager confirmed the HHA did not document bed linens were changed and the bed made with each visit. She also confirmed the HHA's documentation was not consistent with ensuring Patient #11's wound dressing was covered with plastic for bathing. The RN Case Manager confirmed the care plan did not include meal preparation, and stated the HHA was not following the care plan when she prepared the meal for Patient #11.	G 224		
G 229	Patient #11's HHA did not follow the care plan. 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 the RN made on-site visits to the patients' homes no less frequently than every 2 weeks for 1 of 3 patients (Patient #11), who received aide services and whose records were reviewed. This had the potential to interfere with quality and safety of patient care. Findings include: Patient #11 was a 71 year old female who was admitted to the agency on 6/10/14 for SN, PT, OT, and HHA services related to CHF, HTN, and	G 229	Staff education specific to supervision completed on 8/14/14 (see exhibits A, K) A minimum of 15 clinical records will be audited quarterly for compliance with this standard. This will be monitored by the Clinical Manager, or designee, with results forwarded to the Quality Manager. Additional education will be provided as needed based on audit findings.	08/14/14

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G 229	<p>Continued From page 33</p> <p>cellulitis of her left leg. Her POC for the certification period 6/10/14 to 8/08/14 included HHA visits 1-2 times weekly for 5 weeks.</p> <p>Patient #11's record included a form titled "HHA/Homemaker Plan of Care," dated 6/13/14. The plan of care stated included vital sign parameters, bathing instructions, skin care, bathroom cleaning, light housekeeping, changing bed linens and making the bed.</p> <p>1. Supervisory visits were not completed every 2 weeks as follows:</p> <p>HHA visits were on 6/18/14, 6/27/14, 7/01/14, 7/11/14, and 7/18/14. One "Home Health Aide Supervisory Visit," dated 7/20/14 was noted in Patient #11's record, which was 5 weeks after the HHA started. The record did not include any other supervisory visit notes.</p> <p>During a phone interview on 7/23/14 beginning at 10:40 AM, the RN Case Manager reviewed Patient #11's EMR and confirmed HHA supervisory visits were not completed at 2 week intervals. She was able to provide documentation of one visit only, dated 7/20/14 at 11:15 AM.</p> <p>2. Supervision of the HHA was not thorough as follows:</p> <p>a. The HHA care plan included linen change and bed making. However, the HHA did not document she performed these tasks on 6/18/14, 7/01/14, 7/11/14, or 7/18/14.</p> <p>b. Patient #11's HHA care plan included special instructions for the aide to cover the leg wound dressing with a plastic bag before bathing to keep</p>	G 229		

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G 229	<p>Continued From page 34</p> <p>the dressing dry. HHA visits on 6/18/14, 6/27/14 and 7/01/14, did not include documentation the wound dressing was covered for bathing.</p> <p>c. Patient #11's record did not include documentation that vital signs were obtained during the HHA visits.</p> <p>"Home Health Aide Supervisory Visit," dated 7/20/14, and signed by Patient #11's RN Case Manager, noted the source of information was obtained from Patient #11 and her medical record. Also noted by the RN, the care plan was reviewed with Patient #11, and she wrote "Plan continues to be appropriate." The document included a statement "Compliance to Aide Plan," and "Care delivered by aide agrees with plan. Documentation of care matches the plan." The supervisory visit note did not identify the omissions of care such as vital signs, changing bed linens, making the bed, and covering the wound dressing before bathing.</p> <p>During a phone interview on 7/23/14 beginning at 10:40 AM, the RN Case Manager stated the HHA care plan included vital sign parameters so she would expect the HHA to obtain Patient #11's vital signs with each visit. Additionally, she stated meal preparation was not included in the plan of care. The RN Case Manager stated that when she did a supervisory visit, usually she would just ask the patient about the services provided. The RN did not indicate HHA documentation was reviewed for adherence to the plan of care.</p> <p>Patient #11's RN Case Manager did not ensure timely and thorough HHA supervision.</p>	G 229		
G 236	484.48 CLINICAL RECORDS	G 236	See next page	

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G 236	<p>Continued From page 35</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on clinical record review and staff interview it was determined the agency failed to ensure clinical records were kept according to professional standards for 1 of 12 patients, (#6) whose records were reviewed. This failure had the potential for incorrect patient information being passed to health care providers. Findings include:</p> <p>Patient #6 was a 65 year old man admitted to the agency on 6/22/14, for care related to COPD. Additional diagnoses included chronic kidney disease, diabetes and CHF. He received SN, PT and HHA services.</p> <p>Patient #6's printed record was provided to surveyors on 7/21/14. His record included a "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the certification period 6/22/14 to 8/20/14 (POC #1). Typed in the physician signature/date section of POC #1, was the statement " Signed on paper by [MD name] 6/24/14. " However, there was no signature on the form.</p>	G 236	<p>Staff education specific to clinical records standard was completed on 8/14/14. Agency's software vendor was contacted regarding this incident. Agency staff will be monitoring all Plan of Care before sent to physician for completeness (see exhibit C) at time of case conference.</p> <p>A minimum of 15 clinical records will be audited quarterly for compliance with this standard. This will be monitored by the Clinical Manager, or designee, with results forwarded to the Quality Manager.</p> <p>Additional education will be provided as needed based on audit findings. Agency manager will continue to evaluate this occurrence with software vendor.</p>	08/14/14

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G 236	<p>Continued From page 36</p> <p>On 7/22/14 at approximately 3:30 PM, the Agency Manager provided an additional copy of Patient #6's "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for the certification period 6/22/14 to 8/20/14 (POC #2). The physician signature/date section of POC #2 was completed with the physician's handwritten signature and date, 6/24/14. The Agency Manager stated the agency's practice was to file the copy with the handwritten signature in the patient's hard chart and to update the electronic medical record by typing in the name of the physician and date signed.</p> <p>The following differences in the 2 forms were noted:</p> <p>- POC #1</p> <p>Locator 11, "Principal Diagnosis" stated: Chronic Airway Obstruction</p> <p>Locator 13, "Other Pertinent Diagnoses" stated: Chronic Kidney disease, stage III Diabetes with renal manifestations Congestive heart failure Chronic ischemic heart disease Tobacco use disorder</p> <p>-POC #2</p> <p>Locator 11, "Principal Diagnosis" stated: Diabetes with renal manifestations</p> <p>Locator 13, "Other Pertinent Diagnoses" was blank</p> <p>During an interview on 7/23/14 at 3:30 PM, the</p>	G 236			

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G 236	Continued From page 37 Agency Manager reviewed Patient #6's record, including the POC #1 and POC #2. She was unable to explain why the 2 forms did not match. She stated it may have been a problem with the EMR software system. The Agency Manager confirmed the form signed by the physician, POC #2, was not complete and did not include all of Patient #6's diagnoses.	G 236		
G 337	Patient #6's record contained two distinctly different POC's for the same certification period. 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 review of medical records, and staff interview, it was determined the agency failed to ensure the comprehensive assessment included a medication review to evaluate for drug interactions, identify significant side effects, and identify duplicative therapy for 5 of 12 patients, (#1, #4, #6, #7, and #8) whose records were reviewed. Failure to complete a medication review had the potential to place patients at risk for adverse events and potential drug reactions. Findings include: During an interview on 7/22/14 at 1:30 PM, the Agency Manager reviewed the process of medication reconciliation. She stated the EMR has a program called "Medication Checker." She	G 337	Staff education completed on 8/14/14. (see exhibit A). Medication Record and Medication Reconciliation Policies were updated (see exhibits L, M) Process for notifying physician was instituted on 8/13/14 (see exhibit N) A minimum of 15 clinical records will be audited quarterly for compliance with this standard. This will be monitored by the Clinical Manager, or designee, with results forwarded to the Quality Manager. Additional education will be provided as needed based on audit findings.	08/14/14

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G 337	<p>Continued From page 38</p> <p>stated as the clinician enters each medication in the patient record, they will be checked for contraindications, duplicative therapy, allergies, or interactions with other medications and food. She stated the clinicians have been instructed to use the software program during the SOC assessment, while still in the patient home, so teaching can be performed at that time. Additionally, the Agency Manager stated the medication checker is to be used whenever a medication is added to the patient profile.</p> <p>Agency policy stated medication reconciliation is done at time of admission, at time of transfer or resumptions of care, at recertification, and at time of discharge. The agency policy stated a copy of the patient's medication record, along with request for physician to clarify orders will be faxed to the physician for review within 24 hours. Agency policy also stated in the case of a high alert or concern, the admitting (or resuming) clinician will contact the physician for clarification as soon as possible.</p> <p>1. Patient #8 was an 82 year old female admitted to the agency on 7/17/14 for PT services after a fall in which she broke her left arm. Her record and POC for the certification period 7/17/14 to 9/14/14 was reviewed.</p> <p>The SOC comprehensive assessment, dated 7/17/14, included the clinician response to drug regimen review questions of "No problems found during review," and "Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications." However, Patient #8's record included a copy of a screen shot from "Medication Checker," which</p>	G 337		

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G 337	<p>Continued From page 39</p> <p>described a contraindication between Amlodipine and Simvastatin. Additionally, the screen shot noted that grapefruit may increase serum drug concentrations of Simvastatin. Patient #8's record did not include documentation of education related to consuming grapefruit and taking the drug, or of physician notification regarding the contraindicated medications.</p> <p>During an interview on 7/23/14 at 8:00 AM, the Physical Therapist who performed Patient #8's SOC assessment and medication review confirmed a contraindication was noted by the software program "Medication Checker." She stated she waited until the visit was over and she was back in the office before she entered Patient #8's medications into the EMR. She stated that during the SOC assessment she answered the M2000 "Drug Regimen Review," and M2010 "High Risk Drug Education," questions before they were assessed. The Physical Therapist stated the software program will not continue until the questions have been answered, so she entered "No problems," before she knew. She stated she should have gone back into the medical record and amended her documentation, but didn't.</p> <p>Patient #8's medications were not reviewed and reconciled, as necessary, during the SOC assessment.</p> <p>2. Patient #1 was a 100 year old woman admitted to the agency on 7/01/14, for care related to dementia. Additional diagnoses included depressive disorder and hypertension. She received SN, HHA and MSW services.</p>	G 337		

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G 337	<p>Continued From page 40</p> <p>Patient #1's record contained a "Modified Order", dated 7/16/14, and signed by her physician on 7/18/14. It included an order for Lasix 80 mg in the morning and Lasix 40 mg in the afternoon.</p> <p>Patient #1's record also included a medication list, dated 7/21/10. The medication list stated Lasix 80 mg, 1 time per day. It did not include the afternoon dose of Lasix.</p> <p>A visit was made to Patient #1's home on 7/21/14 at 2:30 PM, to observe a HHA visit. Patient #1 lived with her son, who managed her medications. Her medications were reviewed with her son. He confirmed she was taking Lasix 80 mg in the morning and Lasix 40 mg in the afternoon. Her son also stated Patient #1 was taking a stool softener 3 times a day, and had been taking it prior to the start of home health services. The stool softener was not included on Patient #1's POC for the certification period 7/01/14 - 8/30/14, or her current medication list.</p> <p>During an interview on 7/23/14 at 11:15 AM, the RN Case Manager confirmed the medication list was not updated to include the stool softener or the change in the Lasix dose.</p> <p>Patient #1's POC did not include all medications she was taking and her medication list was not updated to reflect a dosage change.</p> <p>3. Patient #6 was a 65 year old man admitted to the agency on 6/22/14, for care related to COPD. Additional diagnoses included chronic kidney disease, diabetes and CHF. He received SN, PT and HHA services.</p> <p>a. Patient #6's POC, signed by his physician on</p>	G 337		

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G 337	<p>Continued From page 41</p> <p>6/24/14, included his current medications. His record also included a copy of a screen shot from "Medication Checker," which described a severe level interaction between 2 of his current medications, Spironolactone and Potassium Chloride. The information stated patients with kidney disease were at increased risk. Patient #6's record did not include documentation to indicate the physician was notified of the interaction. Additionally, there was no documentation of patient education related to the interaction.</p> <p>During an interview on 7/23/14 at 11:35 AM, the RN who completed the Patient #6's SOC assessment reviewed his record, including the POC and medication list. She stated it was her practice to check for medication interactions and use her judgement to determine whether the physician should be notified. She stated she did not feel it was necessary to notify the physician because Patient #6 had been on both medications for a long time. Additionally, she stated it was her practice to document the interactions and how they were reconciled, as well any patient education provided. The RN confirmed there was no documentation related to the medication interaction, or reconciliation.</p> <p>b. Patient #6's record contained a "Modified Order" dated 7/02/14, and signed by his physician on 7/02/14. The order was to increase in his Gabapentin 300 mg, from 2 times a day to 3 times a day. However, Patient #6's medication list was not updated to indicate the increased dose of Gabapentin.</p> <p>c. Patient #6's record contained a "Modified Order" dated 7/10/14 and signed by his physician</p>	G 337		

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G 337	<p>Continued From page 42</p> <p>on 7/11/14. The "Reason for Physician Notification" stated "Request for Orders". It stated, "Pt still having constipation with current bowel program of stool softeners and miralax and is asking if Milk of Mag prn would be appropriate." His physician indicated "yes" on the order form. However, the order did not specify the dosage or frequency of the Miralax or Milk of Magnesia. Additionally, the Miralax and Milk of Magnesia were not added to Patient #6's medication list.</p> <p>d. A visit was made to Patient #6's home on 7/22/14 at 9:00 AM to observe a PT visit. During the visit he stated he had started on a new medication, Metformim. He stated his physician had prescribed it more than a week ago, but he was unable to recall the exact date. Patient #6's record documented 4 visits in the prior week, SN visits on 7/15/14 and 7/17/14, and PT visits on 7/16/14 and 7/18/14. However, Patient #6's medication list was not updated with the new medication.</p> <p>During an interview on 7/23/14 at 3:30 PM, the Agency Manager reviewed Patient #6's record and confirmed the medication list was not updated to reflect the Gabapentin dosage increase, or the new medications, Miralax, Milk of Magnesia and Metformin.</p> <p>Patient #6's record did not include documentation of a comprehensive medication review.</p> <p>4. Patient #7 was a 48 year old female admitted on 5/04/12 for SN and PT services related to CKD Stage III. Additional diagnoses included fitting and adjustment of vascular catheter, lymphedema, DM Type II, HTN, and difficulty walking.</p>	G 337	

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G 337	<p>Continued From page 43</p> <p>Patient #7's POC for the certification period 6/23/14 to 8/21/14 was reviewed and the following was noted:</p> <p>a. The POC included ranges of insulin, without direction for Patient #7 to administer the higher or lower amount of insulin as in the following examples: - Lantus insulin, 40-45 units each AM and 40-45 units each PM. - Novofog 15-20 units before each meal.</p> <p>b. Patient #7's record included a form "Medication Checker," dated 7/22/14, 29 days after SOC on 6/23/14. The form listed Patient #7's medications and identified 1 severe interaction and 9 moderate interactions between her medications. Patient #7's record did not include documentation her physician was notified of the interactions.</p> <p>During a phone interview on 7/23/14 beginning at 12:00 PM, the RN Case Manager reviewed Patient #7's EMR and confirmed her physician had not been contacted to clarify the insulin range orders and was not notified of the medication interactions.</p> <p>Patient #7's physician was not alerted to medication interactions and unclear medication administration instructions.</p> <p>5. Patient #4 was a 63 year old male admitted on 2/08/14 for SN, PT, and OT services related to open wound of the elbow. Additional diagnoses include non-healing surgical wound, chronic pain, sleep disorder, DM Type II, HTN, depressive disorder, and abnormality of gait. His record and POC for the certification 6/8/14 to 8/6/14 was</p>	G 337		

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G 337	<p>Continued From page 44 reviewed.</p> <p>A form titled "Medication Checker" dated 7/22/14, documented 4 moderate interactions between Patient #4's medications, which were not reported to Patient #4's physician. Patient #4's medications were not reviewed for 47 days after his comprehensive assessment was completed, on 6/6/14.</p> <p>During a phone interview on 7/23/14 beginning at 11:45 AM, the RN Case Manager reviewed Patient #4's EMR and confirmed his medication list had changed from the prior recertification period and his physician had not been notified of the medication interactions.</p> <p>Patient #4's medication review was not completed at the time of the recertification assessment.</p>	G 337		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER BONNER GENERAL HOSPITAL HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 602 NORTH THIRD AVENUE SANDPOINT, ID 83864		
(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 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the licensure survey of your home health agency conducted from 7/21/14 - 7/23/14. The surveyors conducting the survey were: Susan Costa, RN, HFS - Team Leader Nancy Bax, RN, BSN, HFS Laura Thompson, RN, BSN, HFS	N 000		
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G143 and G144	N 062	Please see Plan of Correction G143 and G144	08/14/14
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	N 119	Please see Plan of Correction G229	08/14/14

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AUG 18 2014
FACILITY STANDARDS

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

Sheryl L. Richard

TITLE

CEO

(X6) DATE

8/14/2014

Bureau of Facility Standards

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N 119	Continued From page 1 made at least every sixty (60) days. This Rule is not met as evidenced by: Refer to G229	N 119		
N 122	03.07024.SK.NSG.SERV. N122 05. Training, Assignment and Instruction of A Home Health Aide. c. Written instructions for home care, including specific exercises, are prepared by a registered nurse or therapist as appropriate. This Rule is not met as evidenced by: Refer to G224	N 122	Please see Plan of Correction G224	08/14/14
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Refer to G158	N 152	Please see Plan of Correction G158	08/14/14
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	N 155	Please see Plan of Correction G159	08/14/14

Bureau of Facility Standards

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N 155	Continued From page 2 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 159	N 155		
N 165	03.07030.PLAN OF CARE N165 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: m. The patient and his family's teaching needs; This Rule is not met as evidenced by: Refer to G159	N 165	Please see Plan of Correction G159	08/14/14
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	Please see Plan of Correction G164	08/14/14
N 173	03.07030.07.PLAN OF CARE	N 173	see next page	

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N 173	Continued From page 3 N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G337	N 173	Please see Plan of Correction G337	08/14/14
N 177	03.07031.CLINICAL REC. N177 02. Contents. Clinical records must include: c. The plan(s) of care; This Rule is not met as evidenced by: Refer to G236	N 177	Please see Plan of Correction G236	08/14/14