IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

August 25, 2014

Randy Schellhous, Administrator
Encompass Home Health of Western Idaho
433 S. Whitley Drive
Fruitland, Idaho 83619

RE: Encompass Home Health of Western Idaho, CNN 13-7113

Dear Mr. Schellhous:

Based on the survey completed at Encompass Home Health of Western Idaho, on August 7, 2014, by our staff, we have determined the agency is out of compliance with the Medicare Home Health Agency (HHA) **Conditions of Participation of Acceptance of Patients, Plan of Care, and Medical Supervision [42 CFR 484.18] and Skilled Nursing Services [42 CFR 484.30].** To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

Findings of immediate jeopardy to patients' health and safety were identified during the survey and abated prior to the exit conference (Refer to G170). The deficiencies, which caused the conditions to be unmet, substantially limit the capacity of Encompass Home Health of Western Idaho to furnish services of sufficient level and quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

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

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;

- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- 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 **both** the state and federal 2567 forms.

Please complete your Allegation of Compliance/Plan of Correction and submit it to this office by **September 4, 2014.** The Credible Allegation/Plan of Correction for each Condition of Participation and related standard level deficiencies must show compliance no later than **September 22, 2014** (45 days from the survey exit date). We may accept the Credible Allegation of Compliance/Plan of Correction and presume compliance until a revisit survey verifies compliance.

Please note, all references to regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations.*

Consistent with the provisions of 42 CFR 488, Alternative Sanctions for Home Health Agencies, the following remedies will be recommended to the Centers for Medicare/Medicaid (CMS) Region X Office:

- Termination [42 CFR 488.865]
- Suspension of payment for all new Medicare admissions [42 CFR 488.820(b)]

Please be aware, this notice does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal written notice of that determination.

If the revisit survey of the agency finds the one or both of same Conditions of Participation out of compliance, CMS may choose to revise sanctions imposed.

In accordance with 42 CFR 488.745, you have one opportunity to question the deficiencies that resulted in the Condition(s) of Participation being found out of compliance through an informal dispute resolution (IDR) process. To be given such an opportunity, you are required to send your written request and all required information as directed in the attached document.

This request must be received by **September 4, 2014**. If your request for IDR is received after **September 4, 2014,** the request will not be granted. An incomplete IDR process will not delay the effective date of any enforcement action. If the agency wants the IDR panel to consider additional evidence, the evidence and six (6) copies of the evidence must be received 15 calendar days before the IDR meeting [Refer to page 6 of the attached IDR Guidelines].

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626, option 4.

Sincerely,

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/

Enclosures

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
Seattle Regional Office
701 Fifth Avenue, Suite 1600
Seattle, WA 98104

IMPORTANT NOTICE – PLEASE READ CAREFULLY

September 5, 2014

Randy Schellhous, Administrator
Encompass Home Health of Western Idaho
433 South Whitley Drive
Fruitland, ID 83619

CMS Certification Number: 13-7113

Re: Recertification survey 08/07/2014 found CoPs Not Met
- **Immediate Jeopardy abated by survey exit date**

Suspension of payments for new admissions effective 09/20/2014
Termination effective 02/07/2015 if all CoPs not met

Dear Mr. Schellhous:

After careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that Encompass Home Health of Western Idaho no longer meets the requirements for participation as a provider of services in the Medicare program established under Title XVIII of the Social Security Act.

I. BACKGROUND

To participate as a provider of services in the Medicare and Medicaid Programs, a home health agency must meet all of the Conditions of Participation established by the Secretary of Health and Human Services. When a home health agency is found to be out of compliance with the home health agency Conditions of Participation, the facility no longer meets the requirements for participation as a provider of services in the Medicare program.

The Social Security Act Section 1866(b) authorizes the Secretary to terminate a home health agency's Medicare provider agreement if the provider no longer meets the requirements for a home health agency. Regulations at 42 Code of Federal Regulations (CFR) § 489.53 authorize the Centers for Medicare and Medicaid Services (CMS) to terminate Medicare provider agreements when a provider, such as Encompass Home Health of Western Idaho no longer meets the Conditions of Participation.

On August 7, 2014, the Idaho Bureau of Facility Standards (State survey agency) completed a recertification survey at your facility and notified you about an Immediate Jeopardy finding regarding the Medicare Condition of Participation (Cop) Skilled Nursing Services (42 CFR § 484.30). Briefly, the home health agency failed to do the following: to identify and report a significant change in a patient's condition to the physician, to assess a patient's status related to anticoagulant therapy, to monitor a patient's medication management, and to provide patient education related to disease processes and medication management. The State survey agency determined that the deficiency was sufficiently improved to abate the immediate jeopardy by the end of the survey. Based on a review of deficiencies identified during the survey, the following home health agency Conditions of Participation were not met:

- Acceptance of Patients, Plan of Care and Medical Supervision [42 CFR § 484.18], and
- Skilled Nursing Services [42 CFR § 484.30].

The identified deficiencies have been determined to be of such a serious nature as to substantially limit Encompass Home Health of Western Idaho's ability to provide adequate and safe care.

II. Alternative Sanctions

Because Encompass Home Health of Western Idaho is not in compliance with the Conditions of Participation at 42 CFR §§ 484.18 and 484.30, by this letter, we are imposing the following alternative sanction:

Suspension of payment for all new Medicare admissions, as authorized by the Social Security Act, Sections 1891(e) through (f) and implemented at 42 CFR 488.840.

This is effective for new Medicare admissions made on or after **September 20, 2014**. This denial of payment for new admissions also applies to Medicare patients who are members of managed care plans.

If Encompass Home Health of Western Idaho does not meet all the home health agency Conditions of Participation, its Medicare provider agreement will be terminated no later than **February 7, 2015**. We will publish a legal notice in the local newspaper at least fifteen days prior to the termination date.

III. APPEAL RIGHTS

Encompass Home Health of Western Idaho has the right to appeal this determination by requesting a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR § 498.40 et seq. A written request for a hearing must be filed not later than 60 days after the date you receive this letter. Such a request may be made to:

Chief, Civil Remedies Division
Departmental Appeals Board MS 6132
Cohen Building, Room 637-D
330 Independence Avenue, SW
Washington, D.C. 20201

Please also send a copy to: Chief Counsel
Office of General Counsel, DHHS
701 Fifth Avenue, Suite 1600
Seattle, WA 98104

A request for a hearing must identify the specific issues, and findings of fact and conclusions of law with which Encompass Home Health of Western Idaho disagrees. Additionally, Encompass Home Health of Western Idaho must specify the basis for contending that the findings and conclusions are incorrect. Evidence and arguments may be presented at the hearing and you may be represented by legal counsel at your own expense.

If you have further questions, please contact Kate Mitchell of my staff at (206) 615-2432 or at Catherine.mitchell@cms.hhs.gov .

Sincerely,

Patrick Thrift, Manager
Division of Survey and Certification, Seattle

cc: Idaho Bureau of Facility Standards

encompass™
HOME HEALTH

September 04, 2014

Idaho Department of Health and Welfare
3232 Elder Street
P.O. Box 83720
Boise, ID 83720

RECEIVED
SEP 04 2014
FACILITY STANDARDS

RE: Encompass Home Health of Western Idaho, CNN 13-7113

To whom it may concern: Bureau of Facility Standards

The following is the plan of correction to address deficiencies identified at the recent survey ending August 7, 2014.

Please send our regards to the surveyors who conducted the survey with professionalism and courtesy extended to all of our staff.

Best Regards,

Kimberly Lake

Kimberly Lake, RN
Branch Director

1401 Whitley Dr, Suite 13 | Fruitland, ID 83619 | 208.452.4972

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

PRINTED: 08/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	137113		08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCOMPASS HOME HEALTH OF WESTERN IDAHO	433 S WHITLEY DR 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) COMPLETION DATE
G 000	INITIAL COMMENTS A recertification survey was completed at Encompass Home Health of Western Idaho 8/04/14 though 8/07/14. Immediate jeopardy to a patient's health and safety was cited at tag G170. The jeopardy was abated prior to the exit conference. The surveyors conducting the recertification were: Nancy Bax, RN, BSN, HFS Team Lead Don Sylvester, RN, BSN, HFS Acronyms used in this report include: ALF - Assisted Living Facility BG - Blood Glucose CHF - Congestive Heart Failure CKD - Chronic Kidney Disease CM - Case Manager COPD - Chronic Obstructive Pulmonary Disease DM - Diabetes Mellitus DM II - Type 2 Diabetes Mellitus DME - Durable Medical Equipment HH - Home Health HHA - Home Health Aide HTN - Hypertension INR - International Normalized Ratio LPN - Licensed Practical Nurse Mg - Milligrams MSW - Medical Social Work NPO - nothing by mouth OASIS - Outcome and Assessment Information Set OT - Occupational Therapy POC - Plan of Care Pt - Patient PT - Physical Therapy	G 000	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014 RECEIVED SEP 23 2014 FACILITY STANDARDS	09/04/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Regional Administrator	9/2/14 9/4/2014

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 RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care	G 000	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 111	484.10(d) CONFIDENTIALITY OF MEDICAL RECORDS The patient has the right to confidentiality of the clinical records maintained by the HHA. This STANDARD is not met as evidenced by: Based on staff interview and observation, it was determined the agency failed to ensure the patients' right of confidentiality of the clinical information maintained by the agency. This had the potential to result in unauthorized release of patient information. Findings include: During an interview on 8/07/14 at 2:10 PM, the Billing Specialist stated she was responsible for the transmission of OASIS data for this agency as well as 4 other agencies under common ownership. The Billing Specialist stated she maintained security of the data by locking her monitor screen when she was not at her desk. Following the interview, the Billing Specialist was observed returning to her desk where her monitor screen was open and displayed OASIS information. She confirmed she had failed to lock her screen when she left her desk. Patient clinical information was not protected.	G 111	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 114	484.10(e)(1(i-iii) PATIENT LIABILITY FOR PAYMENT Before the care is initiated, the HHA must inform the patient, orally and in writing, of:	G 114	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 114	Continued From page 2 (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to pay. This STANDARD is not met as evidenced by: Based on observation during home visits and staff interview, it was determined the agency failed to ensure patients were informed in writing of the extent to which payment for home health services could be expected, and the charges the individual might have to pay, for 1of 1 patient (Patient #7) whose start of care visit was observed. This had the potential to interfere with patients'/caregivers' ability to make reasonable, informed decisions about financial matters related to the agency's care and treatment. Findings include: Patient #7 was an 85 year old female admitted to the agency on 8/04/14, for SN and PT services related to weakness and recent falls. Her record for the certification period of 8/04/14 to 10/02/14 was reviewed. A visit was made to Patient #7's home on 8/04/14 at 5:00 PM to observe the start of care assessment performed by the RN. During the visit, Patient #7's husband asked the RN if her insurance would pay for the home health services or if they would receive a bill for a portion of the cost. The RN replied, "That's not my end, so I don't know." During an interview on 8/06/14 at 9:15 AM, the	G 114	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 114	Continued From page 3 RN who completed the SOC assessment stated she did not routinely talk to patients about charges for home health services or who paid for the services. She further stated someone in the office would let her know if the patient would have an out-of-pocket expense, otherwise she assumed there would be no co-payment for the patient. She confirmed she did not know how Patient #7's services were covered or whether she would receive a bill for her home health care. Patient #7 was not informed verbally, or in writing, of potential financial liability before services were provided.	G 114	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
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 and patient interview and review of medical records and patient documentation, it was determined the agency failed to ensure care coordination between disciplines for 2 of 11 patients (Patient #2 and #6) who received services from more than one discipline and whose records were reviewed. This interfered with quality and continuity of patient care. Findings include: Patient #2 was an 86 year old female admitted to the agency on 5/16/14, for SN, PT, MSW and HHA services related to HTN and heart disease. Additional diagnoses included atrial fibrillation,	G 143	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 143	Continued From page 4 syncope (fainting), vision impairment in both eyes. muscle weakness, pacemaker, and long term use of anticoagulants. Her record, including the POCs, for the certification periods 5/16/14 to 7/14/14, and 7/15/14 to 9/12/14, was reviewed. a. Patient #2's POC for the certification period 7/15/14 to 9/12/14, and her current medication profile indicated she was to take Furosemide 40 mg, 2 times a day. Furosemide is a diuretic (water pill) used to treat fluid retention. Johns Hopkins Medicine website states: "Diuretics (such as .... furosemide) reduce the amount of fluid in the body and are useful for patients with fluid retention and hypertension. Weigh yourself daily, because a sudden gain in weight is usually due to fluid retention and may require an increase in your water pill (diuretic)." A visit was made to Patient #2's home on 8/04/14 at 3:00 PM, to observe an LPN visit. During the visit, the LPN asked Patient #2 if she had weighed herself. Patient #2 replied she weighed herself every Saturday, and produced a log of her recent weights. The the most recent entry was dated 8/02/14, with recorded weight of 213 pounds. The previous entry was dated 7/25/14, with recorded weight of 206 pounds. The log indicated a weight gain of 7 pounds in one week. Patient #2's RN Case Manager was interviewed on 8/05/14 at 11:30 AM. The RN confirmed Patient #2's weight was being monitored due to her diagnoses and medications. The RN stated she received a message from the LPN regarding Patient #2's visit on 8/03/14, however, the message did not contain information about her 7 pound weight gain.	G 143	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 143	Continued From page 5 Patient #2's LPN did not communicate her sudden weight gain to her RN Case Manager. b. Patient #2's record contained a SN visit note, dated 7/14/14, and signed by the RN Case Manager. It noted she was not taking her Lasix 2 times a day as ordered. The RN documented patient education regarding Lasix and indicated Patient #2 would require follow up assessment to ensure she was taking her Lasix as ordered. The next SN visit note, dated 7/21/14, was completed and signed by the LPN. The note did not include documentation regarding Patient #2's compliance with her Lasix, or education related to Lasix or medication administration. During an interview on 8/05/14 at 11:30 AM, the RN Case Manager confirmed she did not communicate with the LPN regarding Patient #2's need for assessment and education related to her Lasix. Patient #2's RN Case Manager did not effectively coordinate services with the LPN to ensure her needs were met. 2. Patient #6 was a 66 year old male admitted to the agency on 6/14/14, for services related to surgery aftercare. Additional diagnoses included CHF, DM II, cerebral vascular disease, dysphagia, coronary vessel native graft and chronic obstructive bronchial with acute exacerbation. He received SN, PT, OT, ST, and MSW services. His medical record, including the POC, for the certification period 6/14/14 through 8/12/14, was reviewed.	G 143	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 143	Continued From page 6 A "SN Visit Note Report", dated 6/20/14, indicated Patient #6 lived alone and had just been discharged from the hospital after open heart surgery. It further noted Patient #6 had experienced a stroke and heart attack and that he had peg tube. The note also, documented "He looks bad. Lost 1.25 lbs more. NPO. Jevity 6 cans a day. Lengthy talk with MD, re: can he live alone." A "PHYSICIANS VERBAL ORDER" dated 6/20/14 at 7:09 PM, stated, "HH to arrange a dietician consult as soon as possible at [local hospital] laboratory". During an interview on 8/05/14 at 10:20 AM, the RN who took the physician's verbal order on 6/20/14, stated, when she takes an order she sends it to the office and "I wash my hands of it". No documentation was found to indicate a dietician had been contacted. The Clinical Operations Coordinator was interviewed on 8/05/14 at 10:20 AM. She confirmed the dietician consult had not been performed and the physician had not been notified. The RN did not coordinate Patient #6's care to ensure he received the services of a dietician; nor was Patient #6's physician notified the consult did not occur.	G 143	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 156	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/07/2014	09/04/2014

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G 156	Continued From page 7 This CONDITION is not met as evidenced by: Based on observation, medical record review, policy review, observations during home visits and patient and staff interview, it was determined the agency failed to ensure care was provided in accordance with patients' POCs, that the POCs included all pertinent information, and the physician was notified if the POCs were altered or patients' conditions changed. This resulted in unmet patient needs, negative patient outcomes, and care provided without physician authorization. Findings include: 1. Refer to G158 as it relates to the failure of the agency to notify physicians when the POC for patients was altered by missed visits or not otherwise followed. 2. Refer to G159 as it relates to the failure of the agency to ensure all pertinent information was included in patients' POCs. 3. Refer to G160 as it relates to the failure of the agency to consult the physician to approve the POC. 4. Refer to G164 as it relates to the failure of the agency to notify the physician with changes in patients' conditions. The cumulative effect of these negative systemic practices impeded the ability of the agency to provide care of sufficient scope and quality.	G 156	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
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,	G 158	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 158	Continued From page 8 osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review, patient/family member and staff interview, policy review, and observation, it was determined the agency failed to ensure care followed a physician's written plan of care for 8 of 13 patients (#2, #3, #4, #5, #8, #9, #11 and #12) whose records were reviewed. This resulted in unauthorized treatments, as well as, omissions of care, and unmet patient needs. Findings include: 1. Patient #2 was an 86 year old female admitted to the agency on 5/16/14, for SN, PT, MSW and HHA services related to HTN and heart disease. Additional diagnoses included atrial fibrillation, syncope (fainting), muscle weakness and long term use of anticoagulants. Her record, including the POCs, for the certification periods 5/16/14 to 7/14/14, and 7/15/14 to 9/12/14, was reviewed. Patient #2's care did not follow the written POC as follows: a. Patient #2's POC for the certification period 7/15/14 to 9/12/14 included, "Skilled nurse for monitoring and management of effectiveness of anticoagulation therapy regimen and skilled teaching related to anticoagulation management. Skilled Nurse to intervene with effective anticoagulation therapy." Patient #2's POC and medication profile included Coumadin (generic name warfarin), an anticoagulant used to prevent blood clots. The laboratory test used to measure the time it takes for blood to clot is referred to as a Protime. The	G 158	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 158	Continued From page 9 Protime is reported as the International Normalized Ratio (INR). This test monitors whether the patient's Coumadin level is within a safe and therapeutic range. The American Heart Association's Patient's Guide to Taking Coumadin includes the statement, "It is important to monitor the INR (at least once a month and sometimes as often as twice weekly) to make sure that the level of warfarin remains in the effective range. If the INR is too low, blood clots will not be prevented, but if the INR is too high, there is an increased risk of bleeding." Patient #2's record included a SN visit note, dated 6/02/14 and signed by an RN. The note included the statement, "Pt has PT(Protime)/INR due monthly. Can check regarding if physician wants HH to perform." However, there was no documentation that the physician was contacted regarding the blood test. Thirty two days later, a SN visit note, documented on 7/03/14, the RN Case Manager stated the patient reported her last Protime/INR was 2 months ago. The RN Case Manager indicated she called Patient #2's physician's office, confirmed her last Protime/INR was done on 5/12/14, and requested an order for a Protime/INR. Patient #2's record included a SN visit note, dated 7/14/14 and signed by the RN Case Manager. The note stated the RN Case Manager made a phone call to the physician's office to request an order for a Protime/INR. As of 8/04/14, Patient #2's record did not contain a physician's order for a Protime/INR test to	G 158	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 158	Continued From page 10 monitor the effectiveness of her Coumadin dose. Her last Protime/INR test was done on 5/12/14, 12 weeks earlier. A visit was made to Patient #2's home on 8/04/14 at 3:00 PM, to observe a SN visit performed by the LPN. During the visit, Patient #2's son stated her Protime/INR was to be completed at least monthly. During an interview on 8/05/14 at 11:30 AM, the RN Case Manager confirmed Patient #2's Protime/INR had not be tested since her SOC on 5/16/14. She stated she planned to call Patient #2's physician that day to request an order for the blood test. Patient #2's POC was not followed as it related to monitoring and management of her anticoagulation therapy. b. Patient #2's POC for the certification periods 5/16/14 to 7/14/14, and 7/15/14 to 9/12/14, included, "Skilled nurse to provide skilled teaching related to...medication regimen..." i. Patient #2's record contained a PT visit note, dated 6/21/14, and signed by the physical therapist. It documented a new medication, Lasix 40 mg, to be taken 2 times a day, effective 6/19/14. Patient #2's record contained a SN visit note, dated 7/14/14, and signed by the RN Case Manager. It noted she was not taking her Lasix two times a day as ordered. The RN Case Manager documented patient education regarding Lasix and indicated Patient #2 would require follow up assessment to ensure she was	G 158	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 158	Continued From page 11 taking her Lasix as ordered. However, the visit notes from the subsequent SN visits, dated 7/21/14 and 7/28/14, did not document assessment or education related to Lasix. During an interview on 8/05/14 at 11:30 AM, the RN Case Manager confirmed there was no follow up assessment or education related to Lasix. She stated, "She figured it out and I didn't need to address it." ii. A visit was made to Patient #2's home on 8/04/14 at 3:00 PM, to observe an LPN visit. During the visit, the surveyor asked to see her medications. Patient #2's son pointed to a plastic bag containing medication bottles, and a medication box with separate compartments for morning and evening pills each day. The compartments for her morning medications included a Lasix tablet, however, the compartments for her evening medications did not. Patient #2 stated she was taking her Lasix only one time a day. Upon review of Patient #2's medications, additional discrepancies were found: -Patient #2's POCs for both certification periods and current medication profile, included Docusate (a stool softener) to be taken daily, however, it was not in her medication box. She stated she did not have Docusate and was taking Citrucel (a bulk forming laxative) instead. Citrucel was not included on her POC or current medication profile. -Patient #2 stated she was taking Tylenol regularly for pain, however, her POC and current medication profile did not include Tylenol.	G 158	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 158	Continued From page 12 -Patient #2's POC's for both certification periods and current medication profile, included Potassium Gluconate, however, it was not in her medication box or with her other medications. Patient #2 was taking Lasix, a diuretic (water pill). Per the Mayo Clinic website, diuretics eliminate sodium and water through the urine. They can also cause elimination of potassium in the urine, leading to low potassium levels in the blood. Therefore, many patients on diurectics take potassium supplements to replace the potassium lost in the urine. However, Patient #2 was not taking her potassium as ordered. -Patient #2's POCs for both certification periods and current medication profile did not include Amlodipine. The plastic bag containing her medications included 2 bottles labeled Amlodipine 2.5 mg, however, 1 bottle contained white diamond shaped pills and the other bottle contained peach colored round pills. The labels on both bottles indicated the Amlodipine pills were white diamond shaped pills. Patient #2 did not know what the peach colored round pills were or why they were in the incorrect bottle. Additionally, she did not know whether she had been taking them. -Patient #2's POCs for both certification periods and current medication profile included Coumadin 4 mg to be taken daily. Her medication box included 3 Coumadin tablets. One was in the Sunday evening compartment, as she had forgotten to take her medications on Sunday evening. Patient #2 was unable to remember if she had taken a Coumadin tablet that morning (Monday), and there was not a Coumadin tablet in the Monday evening compartment. The other	G 158	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 158	Continued From page 13 2 Coumadin tablets were scattered in 2 evening compartments later in the week, indicating that Patient #2 would not take her Coumadin as ordered the rest of the week. The plastic bag containing her medications included an empty bottle labeled Coumadin 4 mg. Patient #2 stated she was out of Coumadin and was unsure how to obtain a refill on the medication. She stated her physician was out of the office for the next few days. During the home visit, Patient #2 was questioned regarding her medication management. She stated she managed her own medications using a medication box with separate compartments for morning and evening pills each day. She stated the home health nurses had not filled the box or watched her fill the box. Additionally, she stated the nurses had not reviewed all her medications. During an interview on 8/05/14 at 11:30 AM, the RN Case Manager confirmed she had not watched Patient #2 fill her medication box. Patient #2's POC was not followed as it related to patient education regarding her medication regimen. 2. Patient #3 was an 81 year old female admitted to the agency on 1/01/14, for SN, PT, MSW and HHA services related to COPD. Additional diagnoses included pressure ulcers, CHF and muscle weakness. Her record, including the POC, for the certification period 6/30/14 to 8/28/14 was reviewed. a. Patient #3's POC included orders for wound care to her coccyx to be performed on every visit. However, SN visit notes dated 6/30/14, 7/7/14,	G 158	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 158	Continued From page 14 and 7/21/14, did not include documentation of wound care. During an interview on 8/07/14 at 10:15 AM, the Clinical Operations Coordinator reviewed Patient #3's record and confirmed there was no documentation of wound care in SN visit notes dated 6/30/14, 7/7/14, and 7/21/14. Patient #3's SN visit notes did not document wound care provided as ordered in her POC. b. Patient #3's POC was not followed as it related to frequency of visits. Examples include: -Patient #3's POC for the certification period 6/30/14 to 8/28/14, included orders for SN visits 2 times a week for 2 weeks, then 1 time a week for 5 weeks. For week 1 of the certification period, 2 SN visits were ordered, however, only 1 SN visit was documented. There was no indication Patient #3's physician was notified of the missed visit. For week 3 of the certification period, 1 SN visit was ordered, however, no SN visit was documented. There was no indication Patient #3's physician was notified of the missed visit. -Patient #3's record for the certification period 6/30/14 to 8/28/14, included an order for HHA visits 1 time a week for 6 weeks, effective 7/21/14, a Monday. For the week of 7/21/14, 1 HHA visit was ordered, however, no HHA visit was documented. There was no indication Patient #3's physician was notified of the missed visit.	G 158	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 158	Continued From page 15 During an interview on 8/06/14 at 10:50 AM, the Clinical Operations Coordinator reviewed Patient #3's record and confirmed her physician was not notified of the missed SN and HHA visits. Patient #3 did not receive visits as ordered on her POC. c. Patient #3's POC for the certification period 6/30/14 to 8/28/14, included an order for PT to evaluate. However, there was no documentation of a PT evaluation as of 8/06/14. During an interview on 8/06/14 at 10:50 AM, the Clinical Operations Coordinator reviewed Patient #3's record and confirmed a PT evaluation had not occurred. Patient #3 did not receive a PT evaluation as ordered. d. Patient #3's record included a physician order for an MSW consult, dated 7/27/14. However, there was no documentation of an MSW consult as of 8/06/14. During an interview on 8/06/14 at 10:50 AM, the Clinical Operations Coordinator reviewed Patient #3's record and confirmed an MSW consult had not occurred. Patient #3 did not receive an MSW consult as ordered. e. Patient #3's POC for the certification period 6/30/14 to 8/28/14, included an order to notify her physician if her weight was less than 165 pounds or greater than 175 pounds. However, SN visits	G 158	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 158	Continued From page 16 on 6/30/14, 7/07/14, 7/21/14, and 7/29/14, did not include documentation of Patient #3's weight. During an interview on 8/06/14 at 10:50 AM, the Clinical Operations Coordinator reviewed Patient #3's record and confirmed her weight should have been obtained on every visit. Patient #3's weights were not obtained as ordered on her POC. 3. Patient #8 was a 61 year old female admitted to the agency on 3/28/14, for SN services related to Alpha-1 antitrypsin deficiency. Additional diagnoses included COPD. Her record, including the POCs, for the certification periods of 5/27/14 to 7/25/14 and 7/26/14 to 9/23/14, was reviewed. Patient #8's POC for the certification period 7/26/14 to 9/23/14, included, "Skilled nurse to assess/evaluate Co-morbid conditions including Alpha Angiotripsin Deficiency and other conditions that present themselves during the course of this episode to identify changes and intervene to minimize complications." Patient #8's care included an intravenous infusion of Zemaira (used to treat Alpha 1-antitrypsin deficiency in people who have symptoms of emphysema) every other week. The medication was infused through a peripheral IV inserted by the RN on each visit and removed after the infusion was complete. Patient #8's record included a Physician Order dated 7/31/14, that stated, "Skilled nurse visit for recertification and infusion 7/31/14." Her record did not include a SN visit note dated 7/31/14. Patient #8's record included a SN visit note dated	G 158	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 158	Continued From page 17 8/01/14. The note included a recertification assessment, however, the note did not contain documentation to indicate an infusion of Zemaira was performed during the visit or to explain why the infusion was not performed. There was no documentation related to assessment of an IV insertion site. Additionally, there was no documentation to indicate Patient #8's physician was notified the infusion was not completed as ordered. During an interview on 8/06/14 at 11:20 AM, the Clinical Operations Coordinator reviewed Patient #8's record and explained why the infusion was not performed as ordered. She stated the RN called Patient #8 on the afternoon of 7/31/14, to schedule a visit to perform the infusion and the recertification assessment. Patient #8 stated she had gotten tired of waiting for the SN visit, so she and her husband had inserted an IV and completed the infusion themselves. The Clinical Operations Coordinator confirmed Patient #8's infusion was not performed by the RN as ordered, and her physician was not notified that the patient performed the IV insertion and infusion. She confirmed Patient #8 and her husband had not been educated to insert an IV and compete the infusion. Additionally, she confirmed the SN visit note dated 8/01/14, did not include an assessment of the peripheral IV site used by Patient #8 and her husband and it did not include documentation of patient education related to the possibility of infection at the site, and symptoms of infection to report to the nurse. Patient #8's SN visit was not completed as ordered and her physician was not informed of the late visit. Additionally, the RN did not provide	G 158	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 158	Continued From page 18 assessment and interventions to minimize complications. 4. Patient #9 was a 52 year old male admitted to the agency on 3/19/09, for SN services related to a stage 3 pressure ulcer. Additional diagnoses included non-insulin dependent DM, chronic kidney disease, COPD and venous insufficiency. His record, including the POC, for the certification period 6/21/14 to 8/19/14, was reviewed. Patient #9's POC for the certification period 6/21/14 to 8/19/14, included orders for SN to perform decubitus care to Patient #9's sacral wound 3 times a week. The agency's policy, titled Wound/Ulcer Assessment and Management, dated 4/16/01, and revised 5/30/14, included, "At a minimum, the wound/ulcer shall be measured using the following criteria: Once a week for Stage 3 and Stage 4 pressure ulcers and infected wounds." Patient #9's record did not document wound assessments or measurements during weeks 2, 4 and 6 of the certification period. During an interview on 8/06/14 at 10:50 AM, the Clinical Operations Coordinator reviewed Patient #9's record and confirmed his wound was not measured weekly as indicated per the agency's policy for a stage 3 pressure ulcer. Patient #9's wound assessment did not follow the agency's policy. 5. Patient #11 was a 53 year old male admitted to the agency on 4/03/14, for SN and PT services related to muscle weakness. Additional	G 158	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 158	Continued From page 19 diagnoses included back pain and depressive disorder. His record for the certification period 6/02/14 to 7/31/14, was reviewed. During the certification period 6/02/14 to 7/31/14, Patient #11 received PT services only. A PT visit note dated 7/29/14, documented Patient #11's discharge. A SN visit, including a recertification assessment, was documented on 7/30/14. However, Patient #11's POC and physician's orders had ended on 7/29/14, when he was discharged. During an interview on 8/07/14 at 11:00 AM, the Clinical Operations Coordinator reviewed Patient #11's record and confirmed the SN visit was performed after he was discharged from the agency and no physician's order was obtained for the visit. Patient #11 received a SN visit without a physician's order. 6. Patient #4 was an 88 year old male admitted to the agency on 7/22/14 for SN, PT, OT, MSW and HHA services related to congestive heart failure. Additional diagnoses included DM II and diverticulitis of the small intestine. Patient #4's medical record, including the POC, for the certification period 7/22/14 through 9/19/14, was reviewed. Patient #4's POC included orders for OT twice weekly for 4 weeks. His record documented one visit on 7/25/14. No further visits were documented. During an interview on 8/04/14 at 2:30 PM, the	G 158	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 158	Continued From page 20 Clinical Operations Coordinator reviewed the record and confirmed that OT documented one visit dated 7/25/14, and she verified there was no documentation to discontinue therapy. Patient #4 did not receive OT services at the frequency ordered in his POC. 7. Patient #12 was a 76 year old male admitted to the agency on 6/20/14 for SN, PT and OT services related to an open wound with a drain. Additional diagnoses included DM II, atrial fibrillation and CHF. Patient #12's medical record and POC for the certification period 6/20/14 through 8/18/14, was reviewed. Patient #12's POC included orders for OT once weekly for 2 weeks, and twice weekly for 2 weeks. His record documented one visit on 6/25/14. No further visits were documented. The POC noted SN orders to assess and evaluate diabetes. Eleven SN visits were documented. Two of the visit notes, dated, 6/21/14 and 6/25/14, included documentation of blood glucose levels; the other 9 SN visit notes did not. No further information related to Patient #12's diabetes was documented. The Clinical Operations Coordinator was interviewed 8/05/14 at 2:45 PM. She reviewed the medical record and confirmed that OT documented one visit dated 6/25/14. She, also, verified there was no documentation to discontinue therapy. Additionally, she confirmed there were only 2 blood glucose readings documented of the 11 SN visits. Agency staff did not follow Patient #12's POC.	G 158	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 158	Continued From page 21 8. Patient #5 was a 94 year old female admitted to the agency on 7/10/14, for SN, PT, ST, and MSW services related to joint pain in lower leg. Additional diagnoses included DM II and muscle weakness. Her medical record, including the POC, for the certification period 7/10/14 through 9/07/14, was reviewed. The POC included SN orders to assess and evaluate diabetes and perform finger stick blood sugar as needed. A "Vital Signs Report" dated 8/07/14 at 12:22 PM, indicated blood glucose readings were not documented during SN visits dated 7/10/14, 7/17/14, 7/21/14, 7/24/14, 7/29/14, and 8/04/14. During an interview on 8/06/14 at 3:45 PM, the Clinical Operations Coordinator reviewed Patient #5's medical record and confirmed blood glucose readings were not documented during the 6 SN visits. Patient #5's diabetes was not monitored as ordered on his POC.	G 158	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.	G 159	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 159	Continued From page 22 This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure patients' POCs included all pertinent information for 3 of 13 patients (#4, #6 and #8) whose records were reviewed. This had the potential to interfere with continuity and completeness of patient care. Findings include: 1. Patient #8 was a 61 year old female admitted to the agency on 3/28/14, for SN services related to Alpha-1 antitrypsin deficiency. Additional diagnoses included COPD. Her record for the certification period of 5/27/14 to 7/25/14, was reviewed. SN visit notes dated 6/19/14 and 7/03/14, and signed by the RN, documented Patient #8 used oxygen during the night. However, oxygen was not included on Patient #8's POC. During an interview on 8/06/14 at 11:20 AM, the Clinical Operations Coordinator reviewed Patient #8's record and confirmed she used oxygen and it was not included on the POC. Patient #8 used oxygen, however, her POC did not include oxygen. 2. Patient #6 was a 66 year old male admitted to the agency on 6/14/14, for SN, PT, OT, ST, and MSW services related to surgery aftercare. Additional diagnoses included CHF, cerebrovascular disease, dysphagia, coronary vessel native graft and chronic obstructive bronchial with acute exacerbation. His medical	G 159	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 159	Continued From page 23 record and POC for the certification period 6/14/14 through 8/12/14, was reviewed. A SN visit note, dated 6/16/14, and signed by the RN Case Manager, documented Patient #6 wore a defibrillator vest. However, the defibrillator vest was not included on Patient #6's POC. During an interview on 8/05/14 at 3:30 PM, the Clinical Operations Coordinator reviewed Patient #6's record and confirmed the defibrillator vest was not included on his POC. Patient #6's POC did not include a defibrillator vest as DME. 3. Patient #4 was an 88 year old male admitted to the agency on 7/22/14, for SN, PT, OT, MSW, and HHA services related to heart disease. Additional diagnoses included CHF, DM II and diverticulitis of the small intestine. His medical record, including the POC, for the certification period 7/22/14 through 9/19/14, was reviewed. An OT visit note dated 7/25/14, and signed by the occupational therapist, documented a recommendation for toilet grab bar and elevated toilet seat. However, these were not included on Patient #4's POC. During an interview on 8/05/14 at 3:30 PM, the Clinical Operations Coordinator reviewed Patient #4's record and confirmed the toilet grab bar and elevated toilet seat was not included on the POC. Patient #4's POC did not include a toilet grab bar and elevated toilet seat as DME.	G 159	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 160	484.18(a) PLAN OF CARE	G 160	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 160	Continued From page 24 If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan. This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure a physician was consulted to approve the POC for 1 of 13 patients (Patient #2) whose records were reviewed. This resulted in plans of care that were developed and initiated without appropriate physician approval. Findings include: Patient #2 was an 86 year old female admitted to the agency on 5/16/14, for SN, PT, MSW and HHA services related to HTN and heart disease. Additional diagnoses included atrial fibrillation, syncope, muscle weakness and long term use of anticoagulants. Her record for the certification periods of 5/16/14 to 7/14/14, and 7/15/14 to 9/12/14, was reviewed. Patient #2's POC for the certification period 7/15/14 to 9/12/14, included medications, orders for patient assessment and education, and orders for HHA services. The POC included the statement, "The licensed professional whose signature appears in block 23 attests that the physician's orders were received on 7/14/14." Block 23 contained the name of the RN Case Manager. During an interview on 8/05/14 at 11:30 AM, the RN Case Manager stated she did not receive orders from Patient #2's physician on 7/14/14, and she did not call Patient #2's physician to	G 160	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 160	Continued From page 25 verify approval of the POC. She stated she developed the POC based on information given to her by the agency and the patient. She stated the POC was sent to the physician for signature and the signature indicated his approval. The POC was signed by Patient #2's physician on 7/29/14. SN visits were provided on 7/21/14, and 7/28/14, and HHA visits were provided on 7/16/14 and 7/23/14, prior to physician approval of the POC. Patient #2's physician was not consulted to approve her POC following the recertification assessment.	G 160	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on review of clinical records, patient documentation, and staff and patient interview, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the plan of care for 2 of 13 patients (#1 and #2) whose records were reviewed. As a result, physicians were procluded from making changes in patients' POC to ensure their needs were met. Findings include: 1. Patient #2 was an 86 year old female admitted to the agency on 5/16/14, for SN, PT, MSW and HHA services related to HTN and heart disease.	G 164	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 164	Continued From page 26 Additional diagnoses included atrial fibrillation, syncope, muscle weakness and long term use of anticoagulants. Her record, including the POCs, for the certification periods of 5/16/14 to 7/14/14, and 7/15/14 to 9/12/14, was reviewed. Patient #2's POC for the certification period 7/15/14 to 9/12/14, and current medication profile indicated she was to take Furosemide 40 mg, 2 times a day. Furosemide is a diuretic (water pill) used to treat fluid retention. Johns Hopkins Medicine website states: "Diuretics (such as .... furosemide) reduce the amount of fluid in the body and are useful for patients with fluid retention and hypertension. Weigh yourself daily, because a sudden gain in weight is usually due to fluid retention and may require an increase in your water pill (diuretic)." A visit was made to Patient #2's home on 8/04/14 at 3:00 PM, to observe an LPN visit. During the visit, the LPN asked Patient #2 if she had weighed herself. Patient #2 replied she weighed herself every Saturday, and produced a log of her recent weights. The the most recent entry was dated 8/02/14, with recorded weight of 213 pounds. The previous entry was dated 7/25/14, with recorded weight of 206 pounds. The log indicated a weight gain of 7 pounds in one week. Patient #2's RN Case Manager was interviewed on 8/05/14 at 11:30 AM. The RN confirmed Patient #2's weight was being monitored due to her diagnoses and medications. The RN stated she received a message from the LPN regarding Patient #2's visit on 8/03/14, however, the message did not contain information about her 7 pound weight gain. The RN confirmed the weight	G 164	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 164	Continued From page 27 gain was not communicated to Patient #2's physician. Patient #2's sudden weight gain was not communicated to her physician. 2. Patient #1 was an 81 year old male admitted to the agency on 6/26/14, for SN, PT, and OT services related to care following a left hip replacement. Additional diagnoses included paralysis agitans, CHF, cerebrovascular disease, dementia and DM II. Patient #1's record, including the POC for the certification period 6/26/14 through 8/24/14, was reviewed. A SN "Visit Note Report" dated 7/11/14, stated, "...also has a dark bruise on his left forearm that he bumped and has a small skin tear that his wife covered with a piece of gauze". No documentation was found to indicate Patient #1's physician was notified of the injuries. During an interview on 8/06/14 at 4:30 PM, the Clinical Operations Coordinator reviewed Patient #1's record and confirmed his physician was not notified of his bruising and skin tear to his left forearm. Patient #1's physician was not notified of an injury to his skin causing tissue damage.	G 164	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 168	484.30 SKILLED NURSING SERVICES This CONDITION is not met as evidenced by: Based on review of clinical records and patient documentation, observation during home visits, policy review, and patient/family member and	G 168	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 168	Continued From page 28 staff interview, it was determined the HHA failed to ensure skilled nursing services necessary to meet the health and safety needs of patients were implemented in accordance with patients' POCs. This resulted in immediate jeopardy to the health and safety of one patient and the agency's inability to provide consistent care necessary to promote the health and safety of others receiving agency services. Findings include: 1. Refer to G170 as it relates to the failure of the agency to ensure the RN implemented care in accordance with POCs. This was manifested by failure to obtain physician orders, failure to assess a patient's status related to anticoagulant therapy, failure to monitor a patient's medication management, and failure to provide patient education related to disease processes and medication management. These failures created the imminent potential for a patient to sustain serious injury, harm, or death. 2. Refer to G172 as it relates to the failure of the agency to ensure the RN regularly re-evaluated the patients' nursing needs. This was manifested by failure to identify and report a significant change in condition to the physician. 3. Refer to G175 as it relates to the failure of the agency to ensure the RN initiated appropriate preventive and rehabilitative nursing procedures. 4. Refer to G176 as it relates to the failure of the agency to ensure the RN prepared clinical progress notes and coordinated services for patient care. 5. Refer to G180 as it relates to the failure of the agency to ensure the LPN prepared clinical and	G 168	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 168	Continued From page 29 progress notes. The cumulative effect of these negative systemic practices seriously impeded the ability of the agency provide care of sufficient scope and quality.	G 168	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on staff and patient/family member interview, observation, and review of medical records, it was determined the agency failed to ensure SN services were provided in accordance with POCs for 5 of 13 patients (#2, #3, #5, #8, and #9), who received SN care and whose records were reviewed. This failure placed Patient #2 in immediate jeopardy of serious harm, impairment or death; and also created the potential for other patients to experience negative outcomes. Findings include: 1. Patient #2 was an 86 year old female admitted to the agency on 5/16/14, for SN, PT, MSW and HHA services related to HTN and heart disease. Additional diagnoses included atrial fibrillation, syncope (fainting), vision impairment in both eyes, muscle weakness, cardiac pacemaker, and long term use of anticoagulants. Her record, including the POCs, for the certification periods 5/16/14 to 7/14/14, and 7/15/14 to 9/12/14, was reviewed. Patient #2's care did not follow the written POC for SN as follows:	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 170	Continued From page 30 a. Patient #2's POC for the certification period 7/15/14 to 9/12/14, included, "Skilled nurse for monitoring and management of effectiveness of anticoagulation therapy regimen and skilled teaching related to anticoagulation management. Skilled Nurse to intervene with effective anticoagulation therapy." As noted below, the agency did not provide management and monitoring of anticoagulant therapy, necessary to protect her health and safety. Patient #2's POCs for the certification periods 5/16/14 to 7/14/14, and 7/15/14 to 9/12/14, and her current medication profile included Coumadin (generic name warfarin), an anticoagulant used to prevent blood clots. The laboratory test used to measure the time it takes for blood to clot is referred to as a Protime. The Protime is reported as the International Normalized Ratio (INR). If the INR is too low, blood clots will not be prevented, but if the INR is too high, there is an increased risk of bleeding. The FDA prescribing information for warfarin includes the warning "Warfarin sodium can cause major or fatal bleeding." It also states "Perform regular monitoring or INR in all treated patients." It further indicates "The frequency of performing INR should be based on the clinical situation but generally accepted intervals for INR determinations are 1 - 4 weeks. " The American Heart Association's Patient's Guide to Taking Coumadin also indicates INR is to be monitored at least once a month and sometimes as often as twice weekly, to make sure that the level of warfarin remains in the effective range. Patient #2's POCs for both certification periods	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 170	Continued From page 31 and medication profile, also, included Amiodarone, Omeprazole and Tramadol. Each of the 3 medications can increase the anticoagulant effect of Coumadin. Coumadin and Amiodarone were entered into an "Interaction Checker" on the website "Drugs.com," an internationally recognized database and public access website established as a standard for nurses and clinical staff in determination of drug interactions. The website categories interactions as Major, Moderate, and Minor. A major interaction was identified between the 2 medications. The Drug Interaction Report included, "An empiric 30%-50% reduction in anticoagulant dosage has been recommended, in addition to frequent monitoring of the patient and the prothrombin time or International Normalized Ratio (INR)." Coumadin and Omeprazole were, also, entered into the Drugs.com "Interaction Checker." A moderate interaction was identified between the 2 medications. The Drug Interaction Report included, "Using warfarin together with omeprazole may increase the risk of bleeding...you may need a dose adjustment or more frequent monitoring of your prothrombin time or International Normalized Ratio (INR) to safely use both medications." Additionally, Coumadin and Tramadol were entered into the Drugs.com "Interaction Checker." A moderate interaction was identified between the 2 medications. The Drug Interaction Report included, "Using warfarin together with Tramadol may cause you to bleed more easily. You may need a dose adjustment based on your prothrombin time or International Normalized	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 170	Continued From page 32 Ratio (INR)." Patient #2's record included a SN visit note, dated 6/02/14 and signed by an RN. The note included the statement, "Pt has PT(Protime)/INR due monthly. Can check regarding if physician wants HH to perform." However, there was no documentation that the physician was contacted regarding the blood test. Thirty two days later, in a SN visit note, documented on 7/03/14, the RN Case Manager stated that the patient reported her last Protime/INR was 2 months ago. The RN Case Manager indicated she called Patient #2's physician's office, confirmed her last Protime/INR was done on 5/12/14, and requested an order for a Protime/INR. This was the first attempt to obtain a physician's order for a Protime/INR, 48 days after the SOC. The RN Case manager documented a nurse was to call her back, however, there was no documentation of a phone call from the nurse in the physician's office. Additionally, there was no documentation that the RN Case Manager made a follow up call to obtain an order for the Protime/INR. Eleven days later, in an SN visit note, documented on 7/14/14, the RN Case Manager stated she made a phone call to the physician's office to request an order for a Protime/INR, however, there was no documentation of a physician's order for the Protime/INR, or of a follow up phone call to obtain an order. Patient #2's record included a SN visit note dated 7/28/14, and signed by the RN Case Manager. The note included documentation stating Patient #2 went to the emergency room on 7/27/14, after	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 170	Continued From page 33 calling 911 because of severe abdominal pain. Patient#2 was diagnosed in the emergency room with a urinary tract infection and started on Keflex (an antibiotic) 500 mg, 3 times a day for 10 days. The 2015 Nursing Drug Handbook indicates cephalosporin antibiotics, such as Keflex, "May increase the anticoagulant effect (of Coumadin). Monitor patient carefully for bleeding. Reduce anticoagulant dosage as directed." The FDA prescribing information for warfarin includes, "Perform additional INR tests...whenever other medications are initiated..." However, the SN visit note completed by the RN Case Manager on 7/28/14, did not document an attempt to obtain a physician's order for a Protime/INR. Patient #2 was taking 4 medications that could increase the anticoagulant effect of the Coumadin. One of the medications was added after her SOC. However, as of 8/04/14, Patient #2's record did not contain a physician's order for a Protime/INR test to monitor the effectiveness of her Coumadin dose. Her last Protime/INR test was done on 5/12/14, 12 weeks earlier. A visit was made to Patient #2's home on 8/04/14 at 3:00 PM, to observe a SN visit performed by the LPN. During the visit, Patient #2's son stated Patient #2 had not had her Protime/INR checked since May and it was to be completed at least monthly. The LPN stated she would send a message to the RN Case Manager regarding the Protime/INR. During an interview on 8/05/14 at 11:30 AM, the RN Case Manager confirmed Patient #2's Protime/INR had not been tested since her SOC on 5/16/14. The RN Case Manager confirmed	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 170	Continued From page 34 she had not attempted to contact the physician to obtain an order since 7/14/14, 21 days prior. She stated she had not received a message from the LPN regarding the Protime/INR, after the LPN visit on 8/04/14. Patient #2's POC was not followed as it related to monitoring and management of her anticoagulation therapy. The RN Case Manager failed to obtain a physician's order to complete a Protime/INR to assess Patient #2's status related to her anticoagulation therapy. b. Patient #2's POC for the certification periods 5/16/14 to 7/14/14, and 7/15/14 to 9/12/14, included an order for skilled nursing to provide skilled teaching related to her altered cardiovascular status and medication regimen. This was not completed as follows: * Patient #2's record included a Coordination Note, dated 6/19/14 and signed by the RN Case Manager. The note stated the RN Case Manager returned a phone call to Patient #2, who reported increased swelling in her legs, and a weight gain of 5 pounds. The note also documented that Patient #2 stated her son would take her to see her physician that day. The RN Case Manager documented she instructed Patient #2 to weigh herself daily, keep a record of her weights and keep her feet elevated. Patient #2's record contained a PT visit note, dated 6/21/14, and signed by the physical therapist. It documented a new medication, Lasix (generic name Furosemide) 40 mg, to be taken 2 times a day, effective 6/19/14. Lasix is a diuretic (water pill) that helps to rid the body of excess fluids that may cause additional stress to the	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 170	Continued From page 35 heart. Per the National Institutes of Health article, titled Heart failure - Fluids and Diuretics, "When you have heart failure, your heart does not pump out enough blood. This causes fluids to build up in your body." "Diuretics help your body get rid of extra fluid." "Be sure to take your diuretic the way your doctor tells you to." The article also states, "Weigh yourself every morning...call you doctor if your weight goes up by more than 2 to 3 pounds in a day or 5 pounds in a week." Also, per the Mayo Clinic website, patients taking Furosemide are to "Take this medicine exactly as directed by your doctor to benefit your condition as much as possible." The next SN visit, completed by the RN Case Manager, was documented on 7/03/14, 14 days after Patient #2's physician appointment and new order for Lasix. The note did not include documentation of patient education related to Lasix, or indicate whether she was taking her Lasix as ordered. The note documented a patient weight of 207 pounds, however, it did not indicate a review of a daily weight log, or indicate whether Patient #2 was weighing herself daily as instructed. Additionally, the note did not include documentation of patient education or assessment related to obtaining daily weights, to determine if Patient #2 was able to safely use her scale, and accurately measure and log her weight, due to her impaired vision. The next SN visit was documented on 7/14/14, and signed by the RN Case Manager. The note included the statement, "It is discovered that she's using Lasix as a PRN (as needed) and irregular not as one tablet BID (2 times a day) as	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 170	Continued From page 36 ordered. Education provided. She verbalize understanding but will need to follow up to assess compliance." The SN visit note, dated 7/14/14, also documented a patient weight of 212 pounds, an increase of 5 pounds since the previous visit on 7/03/14, when her weight was 207 pounds. The note did not indicate a review of a daily weight log, or indicate whether Patient #2 was weighing herself daily as instructed. There was no documentation Patient #2's physician was notified of her 5 pound weight gain or that she was not taking her Lasix as ordered. The next SN visit, dated 7/21/14, and completed by an LPN, did not contain documentation related to Patient #2's compliance with her Lasix dosage or education related to Lasix. The note documented a patient weight of 207 pounds, however, it did not indicate a review of a daily weight log, or indicate whether Patient #2 was weighing herself daily as instructed. The next SN visit, dated 7/28/14, and completed by the RN Case Manager did not document assessment or education related to Lasix. The note documented a patient weight of 206 pounds, however, it did not indicate a review of a daily weight log, or indicate whether Patient #2 was weighing herself daily as instructed. During an interview on 8/05/14 at 11:30 AM, the RN Case Manager confirmed there was no follow up assessment or education related to Lasix. She confirmed she did not communicate the need for assessment and education related to Lasix or daily weights, to the LPN who completed the SN visit on 7/21/14. Additionally, she confirmed she	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 170	Continued From page 37 did not address the Lasix during her visit on 7/28/14. She stated, "I would say she figured it out and I didn't need to address it." The RN Case Manager was not able to explain how she determined the patient did not require additional education related to Lasix. * A visit was made to Patient #2's home on Monday, 8/04/14 at 3:00 PM, to observe an LPN visit. During the visit, the surveyor asked to see her medications. Patient #2's son pointed to a plastic bag containing medication bottles, and a medication box with separate compartments for morning and evening pills each day. Upon review of Patient #2's medications, significant discrepancies were noted: -It was noted that each morning compartment had 4 pills in it, and each evening compartment contained either 3 or 4 pills However, there were not the same 4 pills in each morning compartment or same 3-4 pills in each evening compartment. Patient #2 stated she divided her pills so there was an even amount in the morning and evening. She stated it did not matter if she was consistent with the time of day she took each medication, as long as she took each of them one time a day. However, this had the potential to result in daily medications being taken either 12 hours or 36 hours apart, rather than every 24 hours as intended and as ordered by her physician. Patient #2's medications included Amiodarone, Coumadin (Warfarin), and Losartan. The National Institutes of Health patient information on Amiodarone states,	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 170	Continued From page 38 "Amiodarone is used to treat and prevent certain types of serious, life-threatening ventricular arrhythmias." "Your doctor will tell you to take amiodarone with or without food; be sure to take it the same way each time. Follow the directions on your prescription label carefully...Take amiodarone exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor." The National Institutes of Health patient information on Coumadin states, "Warfarin may cause severe bleeding that can be life-threatening and even cause death...Take warfarin at around the same time every day. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist to explain any part you do not understand. Take warfarin exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor. Call your doctor immediately if you take more than your prescribed dose of warfarin." The National Institutes of Health patient information on Losartan (used to treat high blood pressure) states "take it at around the same time(s) every day. Follow the directions on your prescription label carefully...Take losartan exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor." -The medication box compartments for Patient #2's morning medications included a Lasix tablet, however, the compartments for her evening medications did not. Patient #2 stated she was taking her Lasix only one time a day. She stated	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 170	Continued From page 39 she did not remember being told to take her Lasix 2 times a day. -Patient #2 was asked when she filled the medication box. She stated she filled it on Saturday evening. The compartments for Sunday and Monday morning were empty, however, the compartment for Sunday evening had 4 pills in it. Patient #2 stated she must have forgotten to take her medications on Sunday evening. -Patient #2's POCs and current medication profile did not include Amlodipine (used to treat HTN and other coronary problems), however, the plastic bag containing Patient #2's medications included 2 bottles labeled Amlodipine 2.5 mg, with instructions to be taken daily. One bottle contained white diamond shaped pills and the other bottle contained peach colored round pills. The labels on both bottles indicated the Amlodipine pills were white diamond shaped pills. White diamond shaped pills were noted in Patient #2's medication box for each day, some in the morning compartments and some in the evening compartments. Patient #2 stated she did not know what the peach colored round pills were or why they were in the incorrect bottle. Additionally, she did not know whether she had been taking the unidentified medication. -Patient #2's POCs for both certification periods and current medication profile included Potassium Gluconate, however, it was not in her medication box or in the bag with her other medications. Patient #2 was taking Lasix, a diuretic (water pill). Per the Mayo Clinic website, diuretics can cause elimination of potassium in the urine, leading to low potassium levels in the blood. Therefore, many patients on diuretics take	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 170	Continued From page 40 potassium supplements to replace the potassium lost in the urine. However, Patient #2 she was not taking her potassium as ordered. The National Institutes of Health website states, "A large drop in potassium level may slow your heartbeat. This can cause you to feel lightheaded or faint. A very low potassium level can even cause your heart to stop. " -Patient #2 had a diagnosis of atrial fibrillation, which greatly increases the risk of a stroke due to a blood clot. Coumadin thins the blood to prevent blood clots. Patient #2's POCs for both certification periods and current medication profile included Coumadin 4 mg to be taken daily. Her medication box included 3 Coumadin tablets. One was in the Sunday evening compartment, as she had forgotten to take her medications on Sunday evening. Patient #2 was unable to remember if she had taken a Coumadin tablet that morning (Monday), and there was not a Coumadin tablet in the Monday evening compartment. The other 2 Coumadin tablets were scattered in 2 evening compartments later in the week, indicating that Patient #2 would not take her Coumadin as ordered the rest of the week. The plastic bag containing her medication bottles included an empty bottle labeled Coumadin 4 mg. Patient #2 stated she was out of Coumadin and was unsure how to obtain a refill on the medication. -Patient #2's POCs for both certification periods and current medication profile included Docusate (a stool softener) to be taken daily, however, it was not in her medication box. She stated she did not have Docusate and was taking Citrucel (a bulk forming laxative) instead. Citrucel was not	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 170	Continued From page 41 included on her POC or current medication profile. -Patient #2 stated she was taking Tylenol regularly for pain, however, her POCs and current medication profile did not include Tylenol. During the home visit, Patient #2 was questioned regarding her medication management. She stated she managed her own medications using a medication box with separate compartments for morning and evening pills each day. She stated she filled the box by herself every week. She stated the home health nurses had not filled the box or watched her fill the box. When asked if the Home Health nurses reviewed all of her medications with her, she replied. "No, you're the first one who's ever done that." During an interview on 8/05/14 at 11:30 AM, the RN Case Manager confirmed she had not reviewed all of Patient #2's medications, or provided education related to her medication management during her 2 episodes of care. Additionally, she confirmed she had not watched Patient #2 fill her medication box. The RN Case Manager stated she was not aware Patient #2 was taking Amlodipine and did not know how long she had been taking it or who prescribed it. Patient #2's POCs for both certification periods included an order for the SN to provide skilled teaching related to altered cardiovascular status and medication regimen. However, patient education was not completed. A Physician's order for blood tests to monitor anticoagulant status was not obtained, resulting in ineffective management of Patient #2's Coumadin	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 170	Continued From page 42 therapy. Her cardiovascular status was not appropriately assessed and pertinent changes in her status were not communicated to her physician. Patient #2 was not educated regarding her disease processes, or her medication regimen. Additionally, the agency failed to ensure Patient #2 was monitoring her weight and taking her medications as ordered. The cumulative effect of these lapses placed Patient #2 in immediate jeopardy of serious harm, impairment or death. NOTE: The agency administrator was notified of the immediate jeopardy on 8/05/14 and provided a Plan of Correction 8/06/14. The Plan of Correction included the following applicable to Patient #2: Procurement of a physician's order for Protime/INR to be completed immediately, increase in frequency of visits, medication reconciliation to be completed immediately, and specific weight parameters obtained, to be reported to physician. Additionally, it included counseling and education of the RN Case Manager. The agency's Plan of Correction was reviewed and accepted. A visit was made to the patient's home on 8/07/14 at 12:15 PM, to verify the plan was implemented. The immediate jeopardy was abated and the agency notified following the home visit. 2. Patient #8 was a 61 year old female admitted to the agency on 3/28/14, for SN services related to Alpha-1 antitrypsin deficiency. Additional diagnoses included COPD. Her record, including the POCs for the certification periods of 5/27/14 to 7/25/14 and 7/26/14 to 9/23/14, was reviewed.	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 170	Continued From page 43 Patient #8's POC the certification period 7/26/14 to 9/23/14, included, "Skilled nurse to assess/evaluate co-morbid conditions including Alpha Angiotripsin Deficiency and other conditions that present themselves during the course of this episode to identify changes and intervene to minimize complications." Patient #8's care included an intravenous infusion of Zemaira (used to treat alpha 1-antitrypsin deficiency in people who have symptoms of emphysema) every other week. The medication was infused through a peripheral IV inserted by the RN on each visit and removed after the infusion was complete. Patient #8's record included a Physician Order dated 7/31/14, that stated, "Skilled nurse visit for recertification and infusion 7/31/14." Her record did not include a SN visit note dated 7/31/14. Patient #8's record included a SN visit note dated 8/01/14. The note included a recertification assessment, however, the note did not contain documentation to indicate an infusion of Zemaira was performed during the visit or to explain why the infusion was not performed. There was no documentation related to assessment of an IV insertion site. Additionally, there was no documentation to indicate Patient #8's physician was notified the infusion was not completed as ordered. During an interview on 8/06/14 at 11:20 AM, the Clinical Operations Coordinator reviewed Patient #8's record and explained why the infusion was not performed as ordered. She stated the RN called Patient #8 on the afternoon of 7/31/14, to schedule a visit to perform the infusion and the recertification assessment. Patient #8 stated she	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 170	Continued From page 44 had gotten tired of waiting for the SN visit, so she and her husband had inserted an IV and completed the infusion themselves. The Clinical Operations Coordinator confirmed Patient #8's infusion was not performed by the RN as ordered, and her physician was not notified that the patient performed the IV insertion and infusion. She confirmed Patient #8 and her husband had not been educated to insert an IV and compete the infusion. Additionally, she confirmed the SN visit note dated 8/01/14, did not include an assessment of the peripheral IV site used by Patient #8 and her husband and it did not include documentation of patient education related to the possibility of infection at the site, and symptoms of infection to report to the nurse. Patient #8's SN visit was not completed as ordered and her physician was not informed of the late visit. Additionally, the RN did not provide assessment and interventions to minimize complications. 3. Patient #9 was a 52 year old male admitted to the agency on 3/19/09, for SN services related to a pressure ulcer. Additional diagnoses included non-insulin dependent DM, chronic kidney disease, COPD and venous insufficiency. His record, including the POC, for the certification period of 6/21/14 to 8/19/14 was reviewed. Patient #9's POC included orders for wound care to be completed on every SN visit. SN visit notes completed on 6/18/14, 6/23/14, 6/25/14, 6/27/14, 7/02/14, 7/07/14, 7/09/14, 7/11/14, 7/18/14, 7/21/14, 7/23/14, 7/25/14, 8/01/14 and 8/04/14, did not include documentation to indicate wound care was provided.	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 170	Continued From page 45 During an interview on 8/06/14 at 10:50 AM, the Clinical Operations Coordinator reviewed Patient #9's record and confirmed the SN visit notes indicated above did not include documentation that wound care was provided. Patient #9's wound care was not provided as ordered in his POC. 4. Patient #3 was an 81 year old female admitted to the agency on 1/01/14, for SN, PT, MSW and HHA services related to COPD. Additional diagnoses included pressure ulcers, CHF and muscle weakness. Her record, including the POC, for the certification period of 6/30/14 to 8/28/14, was reviewed. Patient #3's POC included orders for wound care to her coccyx to be performed on every visit. However, SN visit notes dated 6/30/14, 7/7/14, and 7/21/14, did not include documentation of wound care. During an interview on 8/07/14 at 10:15 AM, the Clinical Operations Coordinator reviewed Patient #3's record and confirmed there was no documentation of wound care in SN visit notes dated 6/30/14, 7/7/14, and 7/21/14. Patient #3's SN visit notes did not document wound care provided as ordered in her POC. 5. Patient #5 was a 94 year old female admitted to the agency on 7/10/14, for SN, PT, ST, and MSW services related to joint pain in lower leg. Additional diagnoses included DM II and muscle weakness. Her medical record, including the POC, for the certification period 7/10/14 through	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 170	Continued From page 46 9/07/14, was reviewed. The POC included SN orders to assess and evaluate diabetes and perform finger stick blood sugar as needed. A "Vital Signs Report" dated 8/07/14 at 12:22 PM, indicated blood glucose readings were not documented during SN visits dated 7/10/14, 7/17/14, 7/21/14, 7/24/14, 7/29/14, and 8/04/14. During an interview on 8/06/14 at 3:45 PM, the Clinical Operations Coordinator reviewed Patient #5's medical record and confirmed blood glucose readings were not documented during the 6 SN visits. Patient #5's diabetes was not monitored as ordered on his POC.	G 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. 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 RN re-evaluated the nursing needs for 3 of 13 patients (#2, #3, #8) whose records were reviewed. This had the potential to result in unmet patient needs and to negatively impact the quality of patient care. Findings include: 1. Patient #2 was an 86 year old female admitted to the agency on 5/16/14, for SN, PT, MSW and HHA services related to HTN and heart disease.	G 172	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 172	Continued From page 47 Additional diagnoses included atrial fibrillation, syncope (fainting), muscle weakness impaired vision in both eyes, and long term use of anticoagulants. Her record, including the POCs, for the certification periods 5/16/14 to 7/14/14, and 7/15/14 to 9/12/14, was reviewed. a. Patient #2's record contained a SN visit note, dated 7/14/14, and signed by the RN Case Manager. It noted she was not taking her Lasix 2 times a day as ordered. The RN Case Manager documented patient education regarding Lasix and indicated Patient #2 would require follow up assessment to ensure she was taking her Lasix as ordered. However, the visit notes from the subsequent SN visits, dated 7/21/14 and 7/28/14, did not document assessment or education related to Lasix. During an interview on 8/05/14 at 11:30 AM, the RN Case Manager confirmed there was no follow-up assessment or education related to Lasix. She stated, "She figured it out and I didn't need to address it." The RN failed to re-evaluate Patient #2's compliance with her medications. b. Patient #2's record contained a SN visit note dated 7/14/14, and signed by the RN Case Manager. The note included a recertification assessment, however, the assessment did not contain an assessment of Patient #2's risk for falls. During an interview on 8/07/14 at 11:30 AM, the Clinical Operations Coordinator confirmed the agency's policy is to complete a fall risk assessment at SOC and recertification. She	G 172	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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G 172	Continued From page 48 reviewed Patient #2's record and confirmed a fall risk assessment was not completed at recertification, as required by agency policy. The RN failed to re-evaluate Patient #2's risk for falls at recertification. 2. Patient #3 was an 81 year old female admitted to the agency on 1/01/14, for SN, PT, MSW and HHA services related to COPD. Additional diagnoses included pressure ulcers, CHF and muscle weakness. Her record, including the POC, for the certification period of 6/30/14 to 8/28/14, was reviewed. Patient #3's POC included orders for SN visits 2 times a week for 2 weeks, then 1 time a week for 5 weeks. Patient #3's POC included orders for wound care to her coccyx to be performed on every visit. However, SN visit notes dated 6/30/14, 7/7/14, and 7/21/14, did not include documentation of wound care and re-evaluation. During an interview on 8/07/14 at 10:15 AM, the Clinical Operations Coordinator reviewed Patient #3's record and confirmed there was no documentation of wound care in SN visit notes dated 6/30/14, 7/7/14, and 7/21/14. Patient #3's SN visit notes did not document re-evaluation of Patient #3's wound. 3. Patient #8 was a 61 year old female admitted to the agency on 3/28/14, for SN services related to Alpha-1 antitrypsin deficiency. Additional diagnoses included COPD. Her record, including the POC, for the certification period of 5/27/14 to 7/25/14, was reviewed.	G 172	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 172	Continued From page 49 Patient #8's care included an intravenous infusion of Zemaira (used to treat alpha 1-antitrypsin deficiency in people who have symptoms of emphysema) every other week. The medication was infused through a peripheral IV inserted by the RN on each visit and removed after the infusion was complete. Patient #8's record included a Physician Order dated 7/31/14, that stated, "Skilled nurse visit for recertification and infusion 7/31/14." Her record did not include a SN visit note dated 7/31/14. Patient #8's record included a SN visit note dated 8/01/14. The note included a recertification assessment, however, the note did not contain documentation to indicate an infusion of Zemaira was performed during the visit or to explain why the infusion was not performed. There was no documentation related to assessment of an IV insertion site. Additionally, there was no documentation to indicate Patient #8's physician was notified the infusion was not completed as ordered. During an interview on 8/06/14 at 11:20 AM, the Clinical Operations Coordinator reviewed Patient #8's record and explained why the infusion was not performed as ordered. She stated the RN called Patient #8 on the afternoon of 7/31/14, to schedule a visit to perform the infusion and the recertification assessment. Patient #8 stated she had gotten tired of waiting for the SN visit, so she and her husband had inserted an IV and completed the infusion themselves. The Clinical Operations Coordinator confirmed Patient #8's infusion was not performed by the RN as ordered, and her physician was not notified	G 172	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 172	Continued From page 50 that the patient performed the IV insertion and infusion. She confirmed Patient #8 and her husband had not been educated to insert an IV and compete the infusion. Additionally, she confirmed the SN visit note dated 8/01/14, did not include an assessment of the peripheral IV site used by Patient #8 and her husband and it did not include documentation of patient education related to the possibility of infection at the site, and symptoms of infection to report to the nurse. The RN did not re-evaluate Patient #8's assessment and education needs.	G 172	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 175	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing procedures. This STANDARD is not met as evidenced by: Based on medical record review, observation, and staff and patient/family member interview it was determined the agency failed to ensure the registered nurse adequately evaluated patients to determine needed preventative or rehabilitative nursing measures for 4 of 13 patients (#1, #2, #5, and #12) whose records were reviewed. This resulted in lack of appropriate nursing assessment for patients with DM, CHF, and anticoagulant therapy. Findings include: 1. Patient #2 was an 86 year old female admitted to the agency on 5/16/14, for SN, PT, MSW and HHA services related to HTN and heart disease. Additional diagnoses included atrial fibrillation, syncope, muscle weakness and long term use of	G 175	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 175	Continued From page 51 anticoagulants. Her record, including the POCs, for the certification periods 5/16/14 to 7/14/14, and 7/15/14 to 9/12/14, was reviewed. Patient #2's POC for the certification period 7/15/14 to 9/12/14 included, "Skilled nurse for monitoring and management of effectiveness of anticoagulation therapy regimen and skilled teaching related to anticoagulation management. Skilled Nurse to intervene with effective anticoagulation therapy." Patient #2's POC and medication profile included Coumadin (generic name warfarin), an anticoagulant used to prevent blood clots. The laboratory test used to measure the time it takes for blood to clot is referred to as a Protime. The Protime is reported as the International Normalized Ratio (INR). The FDA prescribing information for warfarin includes the warning "Warfarin sodium can cause major or fatal bleeding." It also states "Perform regular monitoring or INR in all treated patients." It further indicates "The frequency of performing INR should be based on the clinical situation but generally accepted intervals for INR determinations are 1 - 4 weeks. " The American Heart Association's Patient's Guide to Taking Coumadin also indicates INR is to monitored at least once a month and sometimes as often as twice weekly, to make sure that the level of warfarin remains in the effective range. If the INR is too low, blood clots will not be prevented, but if the INR is too high, there is an increased risk of bleeding. Patient #2's record included a SN visit note, dated 6/02/14 and signed by an RN. The note included	G 175	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 175	Continued From page 52 the statement, "Pt has PT(Protime)/INR due monthly. Can check regarding if physician wants HH to perform." However, there was no documentation the physician was contacted regarding the blood test. Thirty two days later, Patient #2's record included a SN visit note, dated 7/03/14 and signed by the RN Case Manager. The note stated the patient reported Patient #2's last Protime/INR was 2 months ago. The RN indicated she called her physician's office, confirmed her last Protime/INR was done on 5/12/14, and requested an order for a Protime/INR. Eleven days later, Patient #2's record included a SN visit note, dated 7/14/14 and signed by the RN Case Manager. The note stated the RN made a phone call to the physician's office to request an order for a Protime/INR. As of 8/04/14, Patient #2's record did not contain a physician's order for a Protime/INR test to monitor the effectiveness of her Coumadin dose. Her last Protime/INR test was done on 5/12/14, 12 weeks earlier. During an interview on 8/05/14 at 11:30 AM, the RN Case Manager confirmed Patient #2 had not had a blood test to monitor her anticoagulation therapy since the SOC and she had not obtained a physician's order for the test. The RN Case Manager failed to obtain a physician's order for a blood test to monitor her anticoagulation therapy. 2. Patient #1 was an 81 year old male admitted to the agency on 6/26/14, for SN, PT, and OT	G 175	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 175	Continued From page 53 services related to care following a left hip replacement. Additional diagnoses included paralysis agitans, CHF, cerebrovascular disease, dementia and DM II. Patient #1's record, including the POC, for the certification period 6/26/14 through 8/24/14, was reviewed. A "Vital Signs Report" dated 8/07/14 at 12:05 PM, and SN visits dated 6/26/14, 7/02/14, 7/11/14 and 7/16/14, had no weights reported. The Clinical Operations Coordinator was interviewed on 8/07/14 at 2:10 PM. She stated the agency's practice for CHF patients was to record patient weights or ankle circumference on each visit. She also presented an agency education pamphlet for CHF patients, which referenced the importance of weight readings. She confirmed there were no weights or ankle circumferences documented on the visits dated 6/26/14, 7/02/14, 7/11/14 and 7/16/14. Appropriate nursing procedures were not provided in response to Patient #1's congestive heart failure. 3. Patient #12 was a 76 year old male admitted to the agency on 6/20/14 for SN, PT and OT services related to an open wound with a drain. Additional diagnoses included DM II, atrial fibrillation and CHF. Patient #12's medical record, including the POC, for the certification period 6/20/14 through 8/18/14, was reviewed. The POC noted SN orders to assess and evaluate diabetes. Patient #12's POC and medication profile documented a antidiabetic oral medication. Eleven SN visits were documented. Two of the SN visit notes, dated 6/21/14 and	G 175	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 175	Continued From page 54 6/25/14, included blood glucose levels; the other 9 SN visits did not. No further information related to Patient #12's diabetes was documented. The Clinical Operations Coordinator was interviewed 8/05/14 at 2:45 PM. She reviewed the medical record and confirmed there were only 2 blood glucose readings documented of the 11 SN visits. Preventative nursing procedures specified in the POC were not provided in response to Patient #12's diabetes mellitus type II. 4. Patient #5 was a 94 year old female admitted to the agency on 7/10/14, for SN, PT, ST, and MSW services related to joint pain in lower leg. Additional diagnoses included DM II and muscle weakness. Her medical record, including the POC, for the certification period 7/10/14 through 9/07/14, was reviewed. The POC noted SN orders to assess and evaluate diabetes and perform finger stick blood sugar as needed. A SN visit note dated 7/10/14, signed by the RN, documented Patient #5 had a glucometer. A "Vital Signs Report" dated 8/07/14 at 12:22 PM, indicated blood glucose readings were not documented during SN visits dated 7/10/14, 7/17/14, 7/21/14, 7/24/14, 7/29/14 and 8/04/14. An MSW evaluation visit note, dated 8/05/14, signed by the social work assistant, stated, Patient #5 was in need of a glucometer and made a recommendation to add it as DME.	G 175	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 175	Continued From page 55 During an observation of a PT visit on 8/06/14 beginning at 1:30 PM, a surveyor completed a review of DME with Patient #5's daughter. Patient #5's daughter stated Patient #5 had a glucometer, but it was left at her last residence. She said she requested a glucometer from the agency's staff several times. During an interview on 8/06/14 at 3:45 PM, the Branch Director stated, blood glucose testing is done on patients' own glucometers. She reviewed Patient #5's medical record and confirmed the need for a glucometer. She confirmed the 6 SN visit notes referenced above did not include blood glucose readings. Preventative nursing procedures were not provided to assess and evaluate Patient #5's diabetes mellitus type II.	G 175	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on review of patient records, observations, and staff and patient interview, it was determined the agency failed to ensure RNs coordinated services and physicians were informed of changes in patients' conditions for 2 of 13 patients (#2 and #6) who received SN services and whose records were reviewed. This had the potential to result in unmet patient needs and negatively impact continuity and quality of	G 176	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 176	Continued From page 56 patient care. Findings include: 1. Patient #2 was an 86 year old female admitted to the agency on 5/16/14, for SN, PT, MSW and HHA services related to HTN and heart disease. Additional diagnoses included atrial fibrillation, syncope, muscle weakness and long term use of anticoagulants. Her record, including POCs, for the certification periods of 5/16/14 to 7/14/14, and 7/15/14 to 9/12/14, was reviewed. a. Patient #2's record contained a SN visit note, dated 7/14/14, and signed by the RN Case Manager. It noted she was not taking her Lasix 2 times a day as ordered. The RN documented patient education regarding Lasix and indicated Patient #2 would require follow up assessment to ensure she was taking her Lasix as ordered. The next SN visit note, dated 7/21/14, was completed and signed by the LPN. The note did not include documentation regarding Patient #2's compliance with her Lasix, or education related to Lasix or medication administration. During an interview on 8/05/14 at 11:30 AM, the RN Case Manager confirmed she did not communicate with the LPN regarding Patient #2's need for assessment and education related to her Lasix. Patient #2's RN Case Manager did not effectively coordinate services with the LPN to ensure her needs were met. b. Patient #2's POC for the certification period 7/15/14 to 9/12/14 and current medication profile indicated she was to take Furosemide 40 mg, 2 times a day. Furosemide is a diuretic (water pill)	G 176	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 176	Continued From page 57 used to treat fluid retention. Johns Hopkins Medicine website states: "Diuretics (such as .... furosemide) reduce the amount of fluid in the body and are useful for patients with fluid retention and hypertension. Weigh yourself daily, because a sudden gain in weight is usually due to fluid retention and may require an increase in your water pill (diuretic)." A visit was made to Patient #2's home on 8/04/14 at 3:00 PM, to observe an LPN visit. During the visit, the LPN asked Patient #2 if she had weighed herself. Patient #2 replied she weighed herself every Saturday, and produced a log of her recent weights. The the most recent entry was dated 8/02/14, with recorded weight of 213 pounds. The previous entry was dated 7/25/14, with recorded weight of 206 pounds. The log indicated a weight gain of 7 pounds in one week. Patient #2's RN Case Manager was interviewed on 8/05/14 at 11:30 AM. The RN Case Manager confirmed Patient #2's weight was being monitored due to her diagnoses and medications. The RN Case Manager confirmed the weight gain was not communicated to Patient #2's physician. Patient #2's sudden weight gain was not communicated to her physician. 2. Patient #6 was a 66 year old male admitted to the agency on 6/14/14, for services related to surgery aftercare. Additional diagnoses included CHF, DM II, cerebral vascular disease, dysphagia, coronary vessel native graft and chronic obstructive bronchial with acute exacerbation. He received SN, PT, OT, ST, and MSW services. His medical record, including the	G 176	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 176	Continued From page 58 POC, for the certification period 6/14/14 through 8/12/14, was reviewed. A "SN Visit Note Report", dated 6/20/14, indicated Patient #6 lived alone and had just been discharged from the hospital after open heart surgery. It further noted Patient #6 had experienced a stroke and heart attack and that he had peg tube. The note also, documented "He looks bad. Lost 1.25 lbs more. NPO. Jevity 6 cans a day. Lengthy talk with MD, re: can he live alone." A "PHYSICIANS VERBAL ORDER" dated 6/20/14 at 7:09 PM, stated, "HH to arrange a dietician consult as soon as possible at [local hospital] laboratory". During an interview on 8/05/14 at 10:20 AM, the RN who took the physician's verbal order on 6/20/14, stated, when she takes an order she sends it to the office and "I wash my hands of it". No documentation was found to indicate a dietician had been contacted. The Clinical Operations Coordinator was interviewed on 8/05/14 at 10:20 AM. She confirmed the dietician consult had not been performed and the physician had not been notified. The RN did not coordinate Patient #6's care to ensure he received the services of a dietician; nor was Patient #6's phhysician notified the consult did not occur.	G 176	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 180	484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE	G 180	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/07/2014	09/04/2014

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G 180	Continued From page 59 The licensed practical nurse prepares clinical and progress notes. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure LPN notes included complete and consistent information regarding the status of wounds and wound care provided for 1 of 3 patients (#9) who received nursing care from an LPN and whose records were reviewed. This had the potential to compromise continuity of care and assessment of patients' progress. Findings include: Patient #9 was a 52 year old male admitted to the agency on 3/19/09, for SN services related to a pressure ulcer. Additional diagnoses included non-insulin dependent DM, chronic kidney disease, COPD and venous insufficiency. His record, including the POC, for the certification period 6/21/14 to 8/19/14 was reviewed. Patient #9's POC included orders for wound care to be completed on every SN visit. SN visits were completed by an LPN on 6/23/14, 6/25/14, 6/27/14, 7/02/14, 7/07/14, 7/09/14, 7/11/14, 7/21/14, 7/23/14, and 7/25/14. The SN visit notes completed by the LPN did not include documentation of wound assessment or wound care provided. During an interview on 8/06/14 at 10:50 AM, the Clinical Operations Coordinator reviewed Patient #9's record and confirmed the SN visit notes completed by the LPN did not include documentation of wound assessment or wound care provided.	G 180	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 180	Continued From page 60 The LPN failed to document assessment and care of Patient #9's wounds.	G 180	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 185	484.32 THERAPY SERVICES Any therapy services offered by the HHA directly or under arrangement are given by a qualified therapist or by a qualified therapy assistant under the supervision of a qualified therapist and in accordance with the plan of care. 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 therapy services were provided as ordered by the physician for 2 of 4 sampled patients, who had orders to receive OT service (#4 and #12). This resulted in omitted treatments for those patients. The findings include: 1. Patient #4 was an 88 year old male admitted to the agency on 7/22/14 for SN, PT, OT, MSW and HHA services related to CHF. Additional diagnoses included DM II and diverticulosis of the small intestine. Patient #4's medical record and POC for the certification period 7/22/14 through 9/19/14, was reviewed. Patient #4's POC included orders for OT twice weekly for 4 weeks. His record documented one visit on 7/25/14. No further visits were documented. During an interview on 8/04/14 at 2:30 PM, the Clinical Operations Coordinator reviewed the record and confirmed that OT documented one visit and she verified there was no documentation	G 185	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 185	Continued From page 61 to discontinue therapy. Patient #4 did not receive OT services at the frequency ordered in his POC. 2. Patient #12 was a 76 year old male admitted to the agency on 6/20/14 for SN, PT, and OT services related to an open wound with a drain. Additional diagnoses included DM II, atrial fibrillation and CHF. Patient #12's medical record and POC for the certification period 6/20/14 through 8/18/14, was reviewed. Patient #12's POC included orders for OT once weekly for 2 weeks, and twice weekly for 2 weeks. His record documented one visit on 6/25/14. No further visits were documented. The Clinical Operations Coordinator was interviewed 8/05/14 at 2:45 PM. She reviewed the medical record and confirmed that OT documented one visit and she verified there was no documentation to discontinue therapy. Patient #12 did not receive OT services at the frequency ordered in his POC.	G 185	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 195	484.34 MEDICAL SOCIAL SERVICES If the agency furnishes medical social services, those services are given by a qualified social worker or by a qualified social work assistant under the supervision of a qualified social worker, and in accordance with the plan of care. The social worker assists the physician and other team members in understanding the significant social and emotional factors related to the health problems.	G 195	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 195	Continued From page 62 This STANDARD is not met as evidenced by: Based on staff interviews and review of medical records, it was determined the agency failed to ensure social services were provided by a qualified social worker or by a qualified social work assistant under the supervision of a qualified social worker, and in accordance with the plan of care 4 of 6 patients (#2, #3, #4, #6) who received social services visits and whose records were reviewed. This resulted in a lack of assessment and care planning for patients receiving social services and a lack of supervision of Social Work Assistant. Findings include: The Clinical Operations Coordinator was interviewed on 8/04/14 beginning at 1:10 PM. She stated the Social Worker reviews all evaluations and progress notes completed by the Social Work Assistant on a weekly basis. 1. Patient #6 was a 66 year old male admitted to the agency on 6/14/14, for diagnoses related to surgery after care. Additional diagnoses included CHF, DM II, cerebral vascular disease, dysphagia, coronary vessel native graft and chronic obstructive bronchial with acute exacerbation. His medical record, including the POC, for the certification period 6/14/14 through 8/12/14, was reviewed. His POC included orders for medical social services for evaluation to assess social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care; to be followed by collaboration with the physician and nurse to develop a plan of care.	G 195	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 195	Continued From page 63 An "MSW Visit Note", dated 6/26/14, stated the Social Work Assistant completed an initial evaluation. There was no documentation to show the Social Worker had been involved in Patient #6's care. The Clinical Operations Coordinator was interviewed on 8/04/14 beginning at 1:10 PM. She reviewed Patient #6's medical record and confirmed there was no documentation of oversight by the Social Worker. Medical Social Services were not under the supervision of a qualified Social Worker. 2. Patient #4 was an 88 year old male admitted to the agency on 7/22/14, for diagnoses related to heart failure. Additional diagnoses included CHF, DM II and diverticulitis of the small intestine. His medical record, including the POC, for the certification period 7/22/14 through 9/19/14, was reviewed. His POC included orders for medical social services for evaluation to assess social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care: to be followed by collaboration with the physician and nurse to develop a plan of care. An "MSW Visit Note", dated 7/24/14, stated the Social Work Assistant completed an initial evaluation. There was no documentation to show the Social Worker had been involved in Patient #4's care. The Clinical Operations Coordinator was interviewed on 8/04/14 beginning at 1:10 PM. She	G 195	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 195	Continued From page 64 reviewed Patient #4's medical record and confirmed there was no documentation of oversight by the Social Worker. Medical Social Services were not under the supervision of a qualified Social Worker. 3. Patient #2 was an 86 year old female admitted to the agency on 5/16/14, for SN, PT, MSW and HHA services related to HTN and heart disease. Additional diagnoses included atrial fibrillation, syncope, muscle weakness and long term use of anticoagulants. Her record, including the POCs, for the certification periods of 5/16/14 to 7/14/14, and 7/15/14 to 9/12/14, was reviewed. Patient #2's record included an LSW visit note, dated 5/20/14 and signed by the Social Work Assistant. There was no documentation to indicate oversight by the Social Worker or communication between the Social Worker and the Social Work Assistant. During an interview on 8/07/14 at 11:30 AM, the Clinical Operations Coordinator reviewed Patient #2's record and confirmed there was no oversight of the Social Work Assistant's evaluation visit by the Social Worker. Patient #2's Medical Social Services were not provided under the supervision of a qualified Social Worker. 4. Patient #3 was an 81 year old female admitted to the agency on 1/01/14, for SN, PT, MSW and HHA services related to COPD. Additional diagnoses included pressure ulcers, CHF and muscle weakness. Her record, including the POC, for the certification period 6/30/14 to	G 195	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 195	Continued From page 65 8/28/14, was reviewed. Patient #3's record included an order for an MSW evaluation dated 7/27/14. However, no MSW evaluation had occurred as of 8/06/14. During an interview on 8/06/14 at 10:50 AM, the Clinical Operations Coordinator reviewed Patient #3's record and confirmed the MSW evaluation had not been performed. She stated the Social Worker was out of town the previous week, and the visit was not put on her schedule for the current week due to a scheduling error. Patient #3 did not receive a Social Work evaluation as ordered.	G 195	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
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 RN provided written instructions for the home health aide for 2 of 4 patients (#3, #6) who received aide services and whose records were reviewed. This had the potential to negatively impact quality, completeness, and coordination of patient care. Findings include: 1. Patient #6's medical record documented a 66 year old male admitted to the agency on 6/14/14,	G 224	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 224	Continued From page 66 with a diagnoses related to CHF. Additional diagnoses included DM II, cerebral vascular disease, dysphagia, coronary vessel native graft and chronic obstructive bronchial with exacerbation. His medical record including the POC, for the certification period of 6/14/14 through 8/12/14 was reviewed. His POC documented HHA visits were made 2 times a week for 4 weeks to assist with bathing. However, there was no aide care plan documented for this certification period. Home health aide visits were documented on 7/16/14, 7/19/14, 7/22/14,7/25/14, and 7/29/14, during which the aide documented performing services including, but not limited to, vital signs, bathing, hair care, and peri-care. The Clinical Operations Coordinator reviewed Patient #6's record and was interviewed on 8/04/14 beginning at 4:15 PM. She confirmed there was no documentation to indicate an aide care plan. The aide did not have RN written direction as to what care should be provided to Patient #6. Written instructions were not provided to the HHA. 2. Patient #3 was an 81 year old female admitted to the agency on 1/01/14, for SN, PT, MSW and HHA services related to COPD. Additional diagnoses included pressure ulcers, CHF and muscle weakness. Her record, including the POC, for the certification period of 6/30/14 to 8/28/14, was reviewed. Patient #3's record contained a physician's order	G 224	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 224	Continued From page 67 for HHA visits 1 time a week for 6 weeks, effective 7/21/14. The HHA Care Plan was completed and signed by the RN on 8/06/14. However, the first HHA visit was documented on 7/30/14. During the visit on 7/30/14, the HHA documented she completed vital signs and weight, provided a shower, hair care, skin care, nail care, peri care and assistance with dressing. During an interview on 8/06/14 at 12:55 PM, the Clinical Operations Coordinator reviewed Patient #3's record and confirmed the HHA did not have written instructions from the RN when she completed her visit on 7/30/14. HHA services were provided to Patient #3 without written patient care instructions from the RN.	G 224	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 226	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The duties of a home health aide include the provision of hands on personal care, performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance in administering medications that are ordinarily self administered. 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 as an extension of nursing services, as specified in the HHA care plan for 1 of 4 patients (#4) who received aide services and whose record were reviewed. This resulted in a lack of information available to the RN and had	G 226	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 226	Continued From page 68 the potential to result in negative patient outcomes. Findings include: 1. Patient #4 was an 88 year old male who was admitted to the agency on 7/22/14, for SN, PT, OT, MSW, and HHA services related to CHF. Additional diagnoses included DM II, and diverticulitis of the small intestine. His POC for the certification period 7/22/14 to 9/19/14 included HHA visit 2 times weekly for 8 weeks. The "Aide Care Plan Report" dated 7/22/14, was developed for Patient #4 by the RN Case Manager. The aide care plan included instruction for the aide to complete the following during every visit: vital signs with parameters, weight, bathing instructions, skin care, assist with compression stockings, shaving and dressing. However, HHA "Visit Note Report" dated 7/24/14, 7/28/14, 7/31/14, and 8/04/14, did not include documentation of Patient #4's weight. The Clinical Operations Coordinator was interviewed on 8/05/14 at 10:40 AM. She confirmed the HHA did not document weights for Patient #4 as ordered on the aide care plan. Patient #4's HHA did not follow the care plan related to assessing Patient #4's weight.	G 226	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 331	484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.	G 331	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 331	Continued From page 69 This STANDARD is not met as evidenced by: Based on record review, observation, and patient and staff interview, it was determined the agency failed to ensure the initial SOC comprehensive assessment included an examination of identified items of concern for 1 of 1 patient (Patient #7) whose initial assessment was observed. This prevented the agency from developing a complete POC to address all patient needs. Findings include: Patient #7 was an 85 year old female admitted to the agency on 8/04/14, for SN and PT services related to weakness and recent falls. Additional diagnoses included CHF, HTN, non-insulin dependent DM and macular degeneration (a condition that results in loss of vision). Her record for the certification period of 8/04/14 to 10/02/14, was reviewed. A visit was made to Patient #7's home on 8/04/14 at 5:00PM, to observe an initial assessment visit completed by the RN. The assessment was not comprehensive to determine all the patient's needs. Examples include: 1. During the visit, the RN assisted Patient #7 to ambulate across the room to obtain her weight. Upon returning to her chair after ambulating approximately 20 feet, she was observed to be noticeably short of breath (evidenced by increased respiratory rate with short labored breaths). Later in the visit, the RN asked Patient #7 if she ever experienced shortness of breath. Patient #7 denied shortness of breath. The SOC assessment completed by the RN indicated the Patient #7 was never short of	G 331	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 331	Continued From page 70 breath, however, she was observed to be short of breath after ambulating 20 feet. 2. During the visit, the RN asked Patient #7 about her level of pain. She replied she was not experiencing pain at the moment, but indicated she often had pain at night. The RN did not ask additional questions about her nighttime pain. Later in the visit, the surveyor questioned Patient #7 about nighttime pain. She stated arm and shoulder pain often kept her awake at night. Near the end of the visit, Patient #7 told the RN she sometimes got out of bed and sat in her recliner during the night to relieve her arm and shoulder pain. The SOC assessment completed by the RN indicated Patient #7 never experienced pain, however, Patient #7 related significant pain at night. 3. During the visit the RN asked Patient #7 if she had any skin breakdown. She replied she had not noticed problems with her skin. However, Patient #7 had very poor eyesight, due to macular degeneration. Additionally, she spent most of her day in a chair, increasing the risk of pressure to the sacral area. The RN did not examine Patient #7's sacral area or other areas that were covered by clothing. The SOC assessment completed by the RN indicated Patient #7 did not have skin breakdown or redness, however, the RN did not examine all areas of her body. 4. Patient #7's referral information sent by her physician included a list of her current medications. During the visit the RN asked to	G 331	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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	137113		08/07/2014

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G 331	Continued From page 71 see Patient #7's medications. Her husband presented a basket of medications and the RN made a list of the medications in the basket. The list from her physician's office included 2 medications that were not included in the basket, Ventolin inhaler (a bronchodilator used to increase air flow to the lungs) and Simvastatin (used to lower cholesterol in the blood). The RN did not question Patient #7 or her husband about the 2 medications to determine if she was taking the medications as ordered by her physician. The medication profile created by the RN listed the medications presented to her by Patient #7's husband, however, it did not include all the medications on the list from her physician. Additionally, there was no documentation to indicate the RN contacted Patient #7's physician to reconcile the medications in her home with the list from the physician. During an interview on 8/07/14 at 9:45 AM, the RN who completed the SOC assessment reviewed the completed assessment. -The RN confirmed she had observed Patient #7 to be short of breath after ambulating but stated she documented her response to the question rather than her observation of her respiratory status. -The RN confirmed she questioned Patient #7 about her current pain level but did not ask her if she experienced pain at other times of the day or night. -The RN confirmed she did not perform a complete examination of Patient #7's skin. The RN stated she knew Patient #7 because her	G 331	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 331	Continued From page 72 husband had received Home Health care from the agency. The RN stated she had seen Patient #7 walking in her home when she was there within the last 2-3 months to provide SN visits to her husband, so she didn't feel Patient #7 had a potential for skin breakdown. -The RN confirmed she did not compare the medication list from the physician's office with the medications in Patient #7's home to determine discrepancies. Additionally, she confirmed she did not call Patient #7's physician to reconcile her medications with the list from her physician's office. Patient #7's initial assessment was not comprehensive to assess her status and determine her needs.	G 331	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on record review, observations during home visits, staff interview and patient interview, it was determined the agency failed to ensure the drug review was comprehensive for 4 of 13 patients (#2, #5, #7, #8) whose records were reviewed. This resulted in the potential for patients to experience adverse events or negative drug interactions. Findings include:	G 337	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 337	Continued From page 73 1. Patient #2 was an 86 year old female admitted to the agency on 5/16/14, for SN, PT, MSW and HHA services related to HTN and heart disease. Additional diagnoses included atrial fibrillation, syncope, muscle weakness and long term use of anticoagulants. Her record, including the POCs, for the certification periods 5/16/14 to 7/14/14, and 7/15/14 to 9/12/14, was reviewed. A visit was made to Patient #2's home on Monday, 8/04/14 at 3:00 PM, to observe an LPN visit. During the visit, the surveyor asked to see her medications. Patient #2's son pointed to a plastic bag containing medication bottles, and a medication box with separate compartments for morning and evening pills each day. Upon review of Patient #2's medications, discrepancies were found: -Patient #2 was asked when she filled the medication box. She stated she filled it on Saturday evening. The compartments for Sunday morning and Monday morning were empty, however, the compartment for Sunday evening had 4 pills in it. Patient #2 stated she must have forgotten to take her medications on Sunday evening. -It was noted that each morning compartment had 4 pills in it, however, there were not the same 4 pills in each morning compartment. Patient #2 stated she divided her pills so there was an even amount in the morning and evening. She stated it did not matter if she was consistent with the time of day she took each medication, as long as she took each of them one time a day. However, this had the potential to result in daily medications being taken either 12 hours or 36 hours apart,	G 337	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 337	Continued From page 74 rather than every 24 hours as intended. -Patient #2's POCs for both certification periods and current medication profile did not include Amlodipine (an antihypertensive). However, the plastic bag containing her medications included 2 bottles labeled Amlodipine 2.5 mg. One bottle contained white diamond shaped pills and the other bottle contained peach colored round pills. The labels on both bottles indicated the Amlodipine pills were white diamond shaped pills. Patient #2 did not know what the peach colored round pills were or why they were in the incorrect bottle. Additionally, she did not know whether she had been taking the unidentified medication. -Patient #2's current medication profile included Lasix 40 mg, to be taken 2 times a day, effective 6/19/14. The compartments for her morning medications included a Lasix tablet, however, the compartments for her evening medications did not. Patient #2 stated she was taking her Lasix only one time a day. She stated she did not remember being told to take her Lasix 2 times a day. -Both of Patient #2's POCs and current medication profile included Potassium Gluconate, however, it was not in her medication box or in the bag with her other medications. Patient #2 was taking Lasix, a diuretic (water pill). Per the Mayo Clinic website, diuretics eliminate sodium and water through the urine. They can also cause elimination of potassium in the urine, leading to low potassium levels in the blood. Therefore, many patients on diurectics take potassium supplements to replace the potassium lost in the urine. However, Patient #2 was not taking her potassium as ordered. Per the Mayo	G 337	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 337	Continued From page 75 Clinic website, "Low potassium (hypokalemia) refers to a lower than normal potassium level in your bloodstream. Potassium is a chemical (electrolyte) that is critical to the proper functioning of nerve and muscles cells, particularly heart muscle cells...A very low potassium level can be life-threatening and requires urgent medical attention. -Patient #2 had a diagnosis of atrial fibrillation, which greatly increases the risk of a stroke due to a blood clot. Coumadin thins the blood to prevent blood clots. Patient #2's POCs for both certification periods and current medication profile included Coumadin 4 mg to be taken daily. Her medication box included 3 Coumadin tablets. One was in the Sunday evening compartment, as she had forgotten to take her medications on Sunday evening. Patient #2 was unable to remember if she had taken a Coumadin tablet that morning (Monday), and there was not a Coumadin tablet in the Monday evening compartment. The other 2 Coumadin tablets were scattered in 2 evening compartments later in the week, indicating that Patient #2 would not take her Coumadin as ordered the rest of the week. The plastic bag containing her medication bottles included an empty bottle labeled Coumadin 4 mg. Patient #2 stated she was out of Coumadin and was unsure how to obtain a refill on the medication. -Patient #2's POC and current medication profile included Docusate (a stool softener) to be taken daily, however, it was not in her medication box. She stated she did not have Docusate and was taking Citrucel (a bulk forming laxative) instead. Citrucel was not included on her POC or current medication profile.	G 337	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 337	Continued From page 76 -Patient #2 stated she was taking Tylenol regularly for pain, however, her POC and current medication profile did not include Tylenol. During the home visit, Patient #2 was questioned regarding her medication management. She stated she managed her own medications using a medication box with separate compartments for morning and evening pills each day. She stated she filled the box by herself. She stated the Home Health nurses had not filled the box or watched her fill the box. When asked if the Home Health nurses reviewed all of her medications with her she replied. "No, you're the first one who's ever done that." During an interview on 8/05/14 at 11:30 AM, the RN Case Manager confirmed she had not reviewed all of Patient #2's medication, or provided education related to her medication management. Additionally, she confirmed she had not watched Patient #2 fill her medication box. Patient #2's POC and medication profile were not accurate to reflect the medications she was taking. Additionally, her medications were not reviewed to identify discrepancies. 2. Patient #7 was an 85 year old female admitted to the agency on 8/04/14, for SN and PT services related to weakness and recent falls. Additional diagnoses included CHF, HTN, non-insulin dependent DM and macular degeneration (a condition that results in loss of vision). Her record, including the POC, for the certification period 8/04/14 to 10/02/14 was reviewed.	G 337	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 337	Continued From page 77 Patient #7's referral information sent by her physician included a list of her current medications. A visit was made to Patient #7's home on 8/04/14 at 5:00 PM, to observe an RN complete her initial assessment. During the visit the RN asked to see Patient #7's medications. Her husband presented a basket of medications and the RN made a list of the medications in the basket. The list from her physician's office included 2 medications that were not included in the basket, Ventolin inhaler (a bronchodilator used to increase air flow to the lungs) and Simvastatin (used to lower cholesterol in the blood). The RN did not question Patient #7 or her husband about the 2 medications to determine if she was taking the medications as ordered by her physician. During an interview on 8/07/14 at 9:45 AM, the RN who completed the SOC assessment reviewed the completed assessment. The RN confirmed she did not compare the medication list from the physician's office with the medications in Patient #7's home to determine discrepancies. Additionally, she confirmed she did not contact the physician to reconcile the discrepancies between the medications in Patient #7's home and the list from the physician's office. Patient #7's initial assessment did not include a review of all medications to determine discrepancies or non-compliance. 3. Patient #5 was a 94 year old female who was admitted to the agency on 7/10/14 for SN, and PT services related to pain in lower leg. Additional diagnoses included DM II and muscle weakness.	G 337	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 337	Continued From page 78 The following medications were listed on Patient #5's POC for the certification period of 7/10/14 through 9/07/14: -Klonopin, 0.5 mg 1 tablet at bedtime -Lisinopril, 40 mg 1 tablet daily -Metformin, 500 mg 1 tablet daily -Norco, 5-325 mg 1 to 2 tablets every 6 hours as needed for pain -Prilosec, 20 mg 1 tablet daily before a meal -Tramadol, 50 mg 1 tablet every 6 hours as needed for pain -Zoloft, 25 mg 1 tablet daily During a home visit to observe PT services on 8/06/14, beginning at 1:00 PM, a review of medications was completed with Patient #5's daughter. Patient #5's daughter removed all of the bottles of medication from a medication storage container. While reviewing medications it was noted bottles containing the following, were not included in Patient #5's medication profile and POC. -Gabapentin, 300 mg taken by mouth twice a day -Oxubutymin, 5 mg taken by mouth twice a day In an interview on 8/06/14 beginning at 3:00 PM, the Clinical Operations Coordinator reviewed the medication list and confirmed the POC had not been updated, to include all medications. The medication list and POC in Patient #5's medical record were not accurate and current on the date of the home visit. 4. Patient #8 was a 61 year old female admitted to the agency on 3/28/14, for SN services related to Alpha-1 antitrypsin deficiency. Additional	G 337	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 337	Continued From page 79 diagnoses included COPD. Her record, including the POCs, for the certification periods 3/28/14 to 5/26/13, and 5/27/14 to 7/25/14, was reviewed. a. Patient #8's record included an SN visit note dated 4/24/14, and signed by the RN. The note documented new medications prescribed by her physician, Amoxicillin 500 mg to be taken 2 times a day for 10 days and Prednisone 10 mg to be taken bid for 10 days. However, the 2 medications were not added to Patient #8's medication profile. During an interview on 8/06/14 at 11:20 AM, the Clinical Operations Coordinator reviewed Patient #8's record and confirmed her medication profile was not updated to reflect her new medications. Patient #8's medication profile was not accurate to reflect all her medications. b. Patient #8's record included SN visit notes dated 6/19/14 and 7/03/14, and signed by the RN. The notes documented Patient #8 used oxygen during the night. However, oxygen was not included on Patient #8's POC or medication profile. During an interview on 8/06/14 at 11:20 AM, the Clinical Operations Coordinator reviewed Patient #8's record and confirmed she used oxygen and it was not included on her POC or medication profile. Patient #8 used oxygen, however, her POC and medication profile did not include oxygen.	G 337	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
G 339	484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT	G 339	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 339	Continued From page 80 The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure comprehensive assessments occurred during the last 5 days of every 60 day episode for 1 of 8 patients (Patient #8) who received care for more than 60 days and whose records were reviewed. This resulted in the failure of the agency to have a current assessment and POC, and had the potential to impact the quality of patient care. Findings include: Patient #8 was a 61 year old female admitted to the agency on 3/28/14, for SN services related to Alpha-1 antitrypsin deficiency. Additional diagnoses included COPD. Her record, including the POC, for the certification period 5/27/14 to 7/25/14 was reviewed. Patient #8's initial POC was dated 5/27/14 to 7/25/14, and signed by her physician on 5/30/14. Her record included a second POC, dated 7/26/14 to 9/23/14, and unsigned by her physician as of 8/07/14. However, the comprehensive assessment and collection of OASIS data, used to create her POC, was not completed until	G 339	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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G 339	Continued From page 81 8/01/14. During an interview on 8/06/14 at 11:20 AM, the Clinical Operations Coordinator reviewed Patient #8's record and confirmed her comprehensive assessment was not completed during the last 5 days of her certification period. She stated the patient was out of town at that time, and the assessment was delayed until she returned to town. Patient #8's comprehensive assessment was not completed during the last 5 days of her certification period.	G 339	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

G111 Confidentiality of Medical Records

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies:

- Administration/Operations 15.0: Privacy and Confidentiality
- Information Technology 12: Use of EHR System

were completed to confirm compliance to federal and state regulations.
(See Attachment/s A15, IT12)

Inservice 08/09/2014

An inservice was completed with the Billing Specialist in relationship to Privacy and Confidentiality of the patients record. The employee acknowledged the need to lock her screen any time she leaves her desk and will assure in the future that the screen lock is engaged prior to leaving the desk.
(See Attachment/s 5)

Inservice 09/04/2014

An inservice was completed with all staff to assure the understanding of the requirement for privacy and confidentiality per the above reviewed policies.
(See Attachment/s 18)

Ongoing Follow up:

The Regional Vice President, the Regional Administrator, the Clinical Operations Consultant, and the Operations consultant will do random checks of compliance to maintenance of client's confidentiality when doing on site supervisory visits. The Branch Director will monitor for compliance to client confidentiality on the day to day operations of the location. Any deviations from policy will be addressed at the time it is identified.

Allegation of Compliance Date: 09/22/2014

G114 Patient Liability for Payment

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy

- Service Delivery 3.0: Patient Rights

was completed to confirm compliance to federal and state regulations.
(See Attachment S3)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Medicare 101", the specifics regarding the Medicare Benefit, and HIPPA
(See Attachment/s 10)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This inservicing included the requirement to inform the patient both in writing and verbal at the start of care as the extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program, the charges for services that will not be covered by Medicare and the charges that the individual may have to pay. The staff was shown where in the patient's admission binder the information can be found/documented and where in their electronic device the information can be found/documented. It was also discussed that if the clinician performing the visit was not sure of the financial questions the patient may have, they can always call the resources available for

them in the office in order to give the patient a prompt and accurate answer to their financial responsibility concerns.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training **08/26/2014-08/27/2014**

Individualized training was performed with each Case Manager. Part of this training included the requirement to inform the patient both in writing and verbal at the start of care as the extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program, the charges for services that will not be covered by Medicare and the charges that the individual may have to pay. The staff was shown where in the patient's admission binder the information can be found/documented and where in their electronic device the information can be found/documented. It was also discussed that if the clinician performing the visit was not sure of the financial questions the patient may have, they can always call the resources available for them in the office in order to give the patient a prompt and accurate answer to their financial responsibility concerns.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed and the onsite supervisory visits that are completed with the staff members. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of **Compliance Date: 09/22/2014**

G143 Coordination of Patient Services

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 5.0: Coordination of Services
- Service Delivery 6.0: The Physician's Role
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal and state regulations.
(See Attachment S5, S6, S14)

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching
- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 6)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/15/2014

Inservicing occurred by Michele Carr, DPM, Clinical Operations Consultant did inservicing in relationship to wound care, the documentation of the wound care, the follow up needs to the wound care and care coordination needs in relationship to the wound care.
(See Attachment/s 12)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement for coordination of care, when coordination of care should occur, who the coordination of care should occur with, and follow up when the coordination has occurred.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement for coordination of care, when coordination of care should occur, who the coordination of care should occur with, and follow up when the coordination has occurred.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

G156 CONDITION: Acceptance of Patients, POC, Med Supervision

Please refer to the Plan of Correction for:

- G158 Acceptance of Patients, POC, Med Super
- G159 Plan of Care
- G160 Plan of Care
- G164 Periodic Review of the Plan of Care

G 158 Acceptance of Patients, POC, Med Supervision.

On Site Plan of Correction 08/05/2014

At the time of survey, some identified issues were immediately addressed, with a plan of correction implemented and completed for the patient prior to the exit of the surveyors. These issues included:

- Lack of a current PT INR, last PT INR (of record) completed 5/12/2014. There was a PT INR completed in the physician's office on 7/22/2014.
- Lack of follow up to request of PT INR order requests.
- Medication list not consistent with medications in the home.
- Patient not consistently taking medications as prescribed.
- Patient expressed a lack of education to medications.
- Weight not completed at the visit. With lack of follow up to the reported weight that was obtained by the patient.
- Patient's current ordered frequency is insufficient to meet the patients current needs.

(See Attachment/s 17)

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 1.0: Scope Of Services
- Service Delivery 2.0: Admissions/Client Assessment
- Service Delivery 5.0: Coordination of Services
- Service Delivery 6.0: The Physician's Role
- Service Delivery 7.0: Medications
- Service Delivery 9.0: Laboratory Services
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal and state regulations.
(See Attachment S1, S2, S5, S6, S7, S9, S14)

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching
- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 6)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Medicare 101", the specifics regarding the Medicare Benefit, and HIPPA
(See Attachment/s 10)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement for development of the plan of care, following the plan of care, documentation of assessments and interventions, follow up to issues identified, and updating the plan of care as needed.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement for development of the plan of care, following the plan of care, documentation of assessments and interventions, follow up to issues identified, and updating the plan of care as needed.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. The packet review nurse that reviews the POC at admission, resumption and recertification will provide education related to areas requiring improvement or when an area of non-compliance is identified. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

G 159 Plan of Care

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 1.0: Scope Of Services
- Service Delivery 2.0: Admissions/Client Assessment

were completed to confirm compliance to federal and state regulations.
(See Attachment S1, S2)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement for assuring the accuracy of the plan of care in reflecting the patients 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 and any safety measures to protect against injury, instructions for timely discharge or referral and any other appropriate items.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement for assuring the accuracy of the plan of care in reflecting the patients 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 and any safety measures to protect against injury, instructions for timely discharge or referral and any other appropriate items.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. The packet review nurse that reviews the POC at admission, resumption and recertification will provide education related to areas requiring improvement or when an area of non-compliance is identified. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and

quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

G160 Plan of Care

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy:

- Service Delivery 2.0: Admissions/Client Assessment

was completed to confirm compliance to federal and state regulations.
(See Attachment S2)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This inservicing included the requirement to receive a verbal order to approve the proposed plan of care after admission, recertification or resumption. The documentation of the verbal order is maintained on the POC order as the "attestation statement".
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement to receive a verbal order to approve the proposed plan of care after admission, recertification or resumption. The documentation of the verbal order is maintained on the POC order as the "attestation statement".
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

G164 Periodic Review of the Plan of Care

Survey on site Plan of Correction 08/05/2014

At the time of survey, some identified issues were immediately addressed, with a plan of correction implemented and completed for the patient prior to the exit of the surveyors. These issues included:

- Lack of a current PT INR, last PT INR (of record) completed 5/12/2014. There was a PT INR completed in the physician's office on 7/22/2014.
- Lack of follow up to request of PT INR order requests.
- Medication list not consistent with medications in the home.
- Patient not consistently taking medications as prescribed.
- Patient expressed a lack of education to medications.
- Weight not completed at the visit. With lack of follow up to the reported weight that was obtained by the patient.
- Patient's current ordered frequency is insufficient to meet the patients current needs.

(See Attachment/s 17)

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 5.0: Coordination of Services
- Service Delivery 6.0: The Physician's Role
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal and state regulations.
(See Attachment S5, S6, S14)

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching

- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 6)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement for coordination of care, when coordination of care should occur, who the coordination of care should occur with, and follow up when the coordination has occurred.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement for coordination of care, when coordination of care should occur, who the coordination of care should occur with, and follow up when the coordination has occurred.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

G168 CONDITION: Skilled Nursing Services

Please refer to the Plan of Correction for:

- G170 Skilled Nursing Services
- G172 Duties of the Registered Nurse
- G175 Duties of the Registered Nurse
- G176 Duties of the Registered Nurse
- G180 Duties of the Licensed Practical Nurse

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching
- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 6)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.

(See Attachment/s 11)

Inservice 08/15/2014

Inservicing occurred by Michele Carr, DPM, Clinical Operations Consultant did inservicing in relationship to wound care, the documentation of the wound care, the follow up needs to the wound care and care coordination needs in relationship to the wound care.
(See Attachment/s 12)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement for the HHA services to be in accordance with the plan of care.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement for the HHA services to be in accordance with the plan of care.
(See Attachment/s 15)

Follow Up

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

G 172 Duties of the Registered Nurse

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 1.0: Scope Of Services
- Service Delivery 2.0: Admissions/Client Assessment
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal and state regulations.
(See Attachment S1, S2, S14)

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching
- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 7)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/15/2014

Inservicing occurred by Michele Carr, DPM, Clinical Operations Consultant did inservicing in relationship to wound care, the documentation of the wound care, the follow up needs to the wound care and care coordination needs in relationship to the wound care.
(See Attachment/s 12)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement for the nurse to regularly re-evaluate the patients nursing needs.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included requirement for the nurse to regularly re-evaluate the patients nursing needs.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

G175 Duties of the Registered Nurse

Survey on site Plan of Correction 08/05/2014

At the time of survey, some identified issues were immediately addressed, with a plan of correction implemented and completed for the patient prior to the exit of the surveyors. These issues included:

- Lack of a current PT INR, last PT INR (of record) completed 5/12/2014. There was a PT INR completed in the physician's office on 7/22/2014.
- Lack of follow up to request of PT INR order requests.
- Medication list not consistent with medications in the home.
- Patient not consistently taking medications as prescribed.
- Patient expressed a lack of education to medications.
- Weight not completed at the visit. With lack of follow up to the reported weight that was obtained by the patient.
- Patient's current ordered frequency is insufficient to meet the patients current needs.

(See Attachment/s 17)

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 1.0: Scope Of Services
- Service Delivery 2.0: Admissions/Client Assessment
- Service Delivery 5.0: Coordination of Services
- Service Delivery 6.0: The Physician's Role
- Service Delivery 7.0: Medications
- Service Delivery 9.0: Laboratory Services
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal and state regulations.
(See Attachment S1, S2, S5, S6, S7, S9, S14)

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching
- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 6)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.

(See Attachment/s 11)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This inservicing included the requirement to initiate appropriate preventative and rehabilitative nursing procedures.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement to initiate appropriate preventative and rehabilitative nursing procedures.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed and the onsite supervisory visits that are completed with the staff members. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

G180 Duties of the Licensed Practical Nurse

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 14.0: Clinical Records
- Service Delivery 22.0: Wound/Ulcer Assessment and Management

were completed to confirm compliance to federal and state regulations.
(See Attachment S14, S22)

Employee Intervention 08/11/2014

The LPN's employment was terminated due to lack of documentation and not responding to requests from Agency Director for clarification regarding her documentation.

(See Attachment/s 1)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/15/2014

Inservicing occurred by Michele Carr, DPM, Clinical Operations Consultant did inservicing in relationship to wound care, the documentation of the wound care, the follow up needs to the wound care and care coordination needs in relationship to the wound care.
(See Attachment/s 12)

Inservice 8/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This inservicing included the requirement to assure that the plan of care or additional orders are followed, and that documentation related to the assessment, tasks, education, and other patient related activities are appropriately documented and reported to the patients case manager.
(See Attachment/s 13)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

G 185 Therapy Services

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 12.0 : Transfer and/or Discharge from Services

was completed to confirm compliance to federal and state regulations.
(See Attachment S12)

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching
- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 6)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4,9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 09/04/2014

An inservice was completed with all staff to assure the understanding of the requirements when discharging from a discipline or from Home Health Services.
(See Attachment/s 18)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

G195 484.34 MEDICAL SOCIAL SERVICES

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy

- Personnel 1.0: Professional Personnel competency and Supervision

was completed to confirm compliance to federal and state regulations.
(See Attachment P1)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Medicare 101", the specifics regarding the Medicare Benefit, and HIPPA
(See Attachment/s 10)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/15/2015

A Conference Call was completed to address the Medical Social services potential deficiency. The following plan was discussed with the staff voicing understanding.

- Orders for social services will be obtained by physician order to include social services frequency and duration.

-This information will be forwarded to the HH POC/485

- A request will be made to the HCHB data system to provide a Coordination Note type that would allow for a report to be produced that would account for all patients receiving LSW intervention and subsequent documentation with MSW oversight. This would provide accountability of the MSW supervision and increase efficiency in the ongoing auditing process.
- No less than weekly, the MSW will show his/her involvement in the home health patient's care as evidenced by: review of and signature on visit notes and social work evaluations. Changes to the patient's home health plan of care will be noted by the MSW in the patient's medical record via a Coordination Note. A copy of the completed list of patients receiving MSW oversight will be emailed to the Branch Director, the Regional Administer, and the LSWs until a new Coordination Note type can be implemented (see previous bullet point).
- On a weekly basis the Branch Director or their designee will confirm that all evaluations completed the previous week by the LSW has supervision documentation completed by the MSW, and that supervision is contained within the patient's electronic record. Any noncompliance will immediately be addressed with the MSW and copied to the Administrator and Regional Vice President for additional follow up.
- No less than monthly and as needed, a telephone call will be conducted between the MSW and the social work assistant to discuss the social work assistant's caseload, any immediate patient concerns and the projected needs of current patients.
- Following the monthly call, an email will be generated by the MSW and sent to the Branch Director documenting that oversight of the social work assistant has occurred by identification of patients with immediate needs/concerns. This electronic record will be printed and filed in a binder by the Branch Director, as well as, electronically archived. The Clinical Consultant will complete routine audits to ensure that documentation of these supervisory calls are being appropriately maintained.

(See Attachment/s 19)

Follow up:

- Compliance will be immediate and ongoing
- 10% of records with patients receiving social work services will be reviewed for 3 months or until 90% compliance has been achieved. Then 5% of patient records will be reviewed to ensure continued compliance for a total of 1 year.
- Compliance will be monitored by Clinical Field Staff Supervisor and Branch Director

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Allegation of Compliance Date: 09/22/2014

G224 Assignment and Duties of the Home Health Aide

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Personnel 2.0: Home Health Aide Competency and Supervision
- Service Delivery 2.0: Admissions/Client Assessment

were completed to confirm compliance to federal and state regulations.
(See Attachment P2, S2)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4.9)

Inservice 08/13/2014

The Agency Director, Kimberly Lake RN and the Clinical Operations Consultant, Tracy Russell LPN, met with the Home Health Aide to discuss the requirement for a home health aide plan of care prior to providing any care for the patient. It was also discussed the need to notify the case manager of any requests for alterations to the plan of care. The Home Health Aide is to notify the Agency Director if a Home Health Aide plan of care is not completed prior to a scheduled visit or if needed alterations to the plan of care are not completed in a timely manner.
(See Attachment/s 7)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care

- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement to assure that all patients receiving HHA services has a plan of care completed prior to any scheduled visits.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement to assure that all patients receiving HHA services has a plan of care completed prior to any scheduled visits.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

G226 Assignment and Duties of the Home Health Aide

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Personnel 2.0: Home Health Aide Competency and Supervision
- Service Delivery 2.0: Admissions/Client Assessment

were completed to confirm compliance to federal and state regulations.
(See Attachment P2, S2)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4,9)

Inservice 08/13/2014

The Agency Director, Kimberly Lake RN and the Clinical Operations Consultant, Tracy Russell LPN, met with the Home Health Aide to discuss the requirement for a home health aide plan of care prior to providing any care for the patient. When completing the care, the HHA needs to complete all delegated tasks. If a task cannot or is not completed the case manager must be notified. It was also discussed the need to notify the case manager of any requests for alterations to the plan of care. The Home Health Aide is to notify the Agency Director if a Home Health Aide plan of care is not completed prior to a scheduled visit or if needed alterations to the plan of care are not completed in a timely manner.
(See Attachment/s 7)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement to assure that all patients receiving HHA services has a plan of care completed prior to any scheduled visits.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement to assure that all patients receiving HHA services has a plan of care completed prior to any scheduled visits.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

G331 Initial Assessment Visit

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 1.0: Scope Of Services
- Service Delivery 2.0: Admissions/Client Assessment
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal and state regulations.
(See Attachment S1, S2, S14)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement for the completion of a comprehensive assessment utilizing the OASIS C guidance manual.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement for the completion of a comprehensive assessment utilizing the OASIS C guidance manual. (See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

G337 Drug Regimen Review

Survey on site Plan of Correction 08/05/2014

At the time of survey, some identified issues were immediately addressed, with a plan of correction implemented and completed for the patient prior to the exit of the surveyors. These issues included:

- Lack of a current PT INR, last PT INR (of record) completed 5/12/2014. There was a PT INR completed in the physician's office on 7/22/2014.
- Lack of follow up to request of PT INR order requests.
- Medication list not consistent with medications in the home.
- Patient not consistently taking medications as prescribed.
- Patient expressed a lack of education to medications.
- Weight not completed at the visit. With lack of follow up to the reported weight that was obtained by the patient.
- Patient's current ordered frequency is insufficient to meet the patients current needs.

(See Attachment/s 17)

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 1.0: Scope Of Services
- Service Delivery 2.0: Admissions/Client Assessment
- Service Delivery 5.0: Coordination of Services
- Service Delivery 6.0: The Physician's Role
- Service Delivery 7.0: Medications
- Service Delivery 9.0: Laboratory Services
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal and state regulations.
(See Attachment S1, S2, 55, S6, S7, S9, S14)

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching
- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 6)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4,9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.

(See Attachment/s 11)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement the review of medications and the reconciliation of the medications in coordination with the physician.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement the review of medications and the reconciliation of the medications in coordination with the physician.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

G339 Update of the Comprehensive Assessment

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 10.0: Client Reassessment/Recertification

was completed to confirm compliance to federal and state regulations.
(See Attachment S10)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4,9)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Medicare 101", the specifics regarding the Medicare Benefit, and HIPPA
(See Attachment/s 10)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This inservicing included the requirement complete the recertification in the 5 day window of the last 5 days of the previous episode.
(See Attachment/s 13)

Follow Up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N022 ADM. GOV. Body

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies:

- Administration/Operations 15.0: Privacy and Confidentiality
- Information Technology 12: Use of EHR System

were completed to confirm compliance to federal and state regulations.
(See Attachment/s A15, IT12)

Inservice 08/09/2014

An inservice was completed with the Billing Specialist in relationship to Privacy and Confidentiality of the patients record. The employee acknowledged the need to lock her screen any time she leaves her desk and will assure in the future that the screen lock is engaged prior to leaving the desk.
(See Attachment/s 5)

Inservice 09/04/2014

An inservice was completed with all staff to assure the understanding of the requirement for privacy and confidentiality per the above reviewed policies.
(See Attachment/s 18)

Ongoing Follow up:

The Regional Vice President, the Regional Administrator, the Clinical Operations Consultant, and the Operations consultant will do random checks of compliance to maintenance of client's confidentiality when doing on site supervisory visits. The Branch Director will monitor for compliance to client confidentiality on the day to day operations of the location. Any deviations from policy will be addressed at the time it is identified.

Allegation of Compliance Date: 09/22/2014

N039

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy

- Service Delivery 3.0: Patient Rights

was completed to confirm compliance to federal and state regulations.
(See Attachment S3)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Medicare 101", the specifics regarding the Medicare Benefit, and HIPPA
(See Attachment/s 10)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This inservicing included the requirement to inform the patient both in writing and verbal at the start of care as the extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program, the charges for services that will not be covered by Medicare and the charges that the individual may have to pay. The staff was shown where in the patient's admission binder the information can be found/documented and where in their electronic device the information can be found/documented. It was also discussed that if the clinician performing the visit was not sure of the financial questions the patient may have, they can always call the resources available for

them in the office in order to give the patient a prompt and accurate answer to their financial responsibility concerns.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement to inform the patient both in writing and verbal at the start of care as the extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program, the charges for services that will not be covered by Medicare and the charges that the individual may have to pay. The staff was shown where in the patient's admission binder the information can be found/documented and where in their electronic device the information can be found/documented. It was also discussed that if the clinician performing the visit was not sure of the financial questions the patient may have, they can always call the resources available for them in the office in order to give the patient a prompt and accurate answer to their financial responsibility concerns.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed and the onsite supervisory visits that are completed with the staff members. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N040

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy

- Service Delivery 3.0: Patient Rights

was completed to confirm compliance to federal and state regulations.
(See Attachment S3)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Medicare 101", the specifics regarding the Medicare Benefit, and HIPPA
(See Attachment/s 10)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This inservicing included the requirement to inform the patient both in writing and verbal at the start of care as the extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program, the charges for services that will not be covered by Medicare and the charges that the individual may have to pay. The staff was shown where in the patient's admission binder the information can be found/documented and where in their electronic device the information can be found/documented. It was also discussed that if the clinician performing the visit was not sure of the financial questions the patient may have, they can always call the resources available for

them in the office in order to give the patient a prompt and accurate answer to their financial responsibility concerns.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement to inform the patient both in writing and verbal at the start of care as the extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program, the charges for services that will not be covered by Medicare and the charges that the individual may have to pay. The staff was shown where in the patient's admission binder the information can be found/documented and where in their electronic device the information can be found/documented. It was also discussed that if the clinician performing the visit was not sure of the financial questions the patient may have, they can always call the resources available for them in the office in order to give the patient a prompt and accurate answer to their financial responsibility concerns.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed and the onsite supervisory visits that are completed with the staff members. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N041

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy

- Service Delivery 3.0: Patient Rights

was completed to confirm compliance to federal and state regulations.
(See Attachment S3)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Medicare 101", the specifics regarding the Medicare Benefit, and HIPPA
(See Attachment/s 10)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This inservicing included the requirement to inform the patient both in writing and verbal at the start of care as the extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program, the charges for services that will not be covered by Medicare and the charges that the individual may have to pay. The staff was shown where in the patient's admission binder the information can be found/documented and where in their electronic device the information can be found/documented. It was also discussed that if the clinician performing the visit was not sure of the financial questions the patient may have, they can always call the resources available for

them in the office in order to give the patient a prompt and accurate answer to their financial responsibility concerns.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement to inform the patient both in writing and verbal at the start of care as the extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program, the charges for services that will not be covered by Medicare and the charges that the individual may have to pay. The staff was shown where in the patient's admission binder the information can be found/documented and where in their electronic device the information can be found/documented. It was also discussed that if the clinician performing the visit was not sure of the financial questions the patient may have, they can always call the resources available for them in the office in order to give the patient a prompt and accurate answer to their financial responsibility concerns.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed and the onsite supervisory visits that are completed with the staff members. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N062

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 5.0: Coordination of Services
- Service Delivery 6.0: The Physician's Role
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal and state regulations.
(See Attachment S5, S6, S14)

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching
- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 6)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/15/2014

Inservicing occurred by Michele Carr, DPM, Clinical Operations Consultant did inservicing in relationship to wound care, the documentation of the wound care, the follow up needs to the wound care and care coordination needs in relationship to the wound care.
(See Attachment/s 12)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement for coordination of care, when coordination of care should occur, who the coordination of care should occur with, and follow up when the coordination has occurred.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement for coordination of care, when coordination of care should occur, who the coordination of care should occur with, and follow up when the coordination has occurred.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N091

Survey on site Plan of Correction 08/05/2014

At the time of survey, some identified issues were immediately addressed, with a plan of correction implemented and completed for the patient prior to the exit of the surveyors. These issues included:

- Lack of a current PT INR, last PT INR (of record) completed 5/12/2014. There was a PT INR completed in the physician's office on 7/22/2014.
- Lack of follow up to request of PT INR order requests.
- Medication list not consistent with medications in the home.
- Patient not consistently taking medications as prescribed.
- Patient expressed a lack of education to medications.
- Weight not completed at the visit. With lack of follow up to the reported weight that was obtained by the patient.
- Patient's current ordered frequency is insufficient to meet the patients current needs.

(See Attachment/s 17)

Plan **8/8/2014**

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 1.0: Scope Of Services
- Service Delivery 2.0: Admissions/Client Assessment
- Service Delivery 5.0: Coordination of Services
- Service Delivery 6.0: The Physician's Role
- Service Delivery 7.0: Medications
- Service Delivery 9.0: Laboratory Services
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal and state regulations.
(See Attachment S1, S2, S5, S6, S7, S9, S14)

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching
- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 6)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.

(See Attachment/s 11)

Inservice 08/15/2014

Inservicing occurred by Michele Carr, DPM, Clinical Operations Consultant did inservicing in relationship to wound care, the documentation of the wound care, the follow up needs to the wound care and care coordination needs in relationship to the wound care.
(See Attachment/s 12)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement for the HHA services to be in accordance with the plan of care.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement for the HHA services to be in accordance with the plan of care.
(See Attachment/s 15)

Follow Up

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N093 part 1

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 1.0: Scope Of Services
- Service Delivery 2.0: Admissions/Client Assessment
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal and state regulations.
(See Attachment S1, S2, S14)

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching
- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 7)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/15/2014

Inservicing occurred by Michele Carr, DPM, Clinical Operations Consultant did inservicing in relationship to wound care, the documentation of the wound care, the follow up needs to the wound care and care coordination needs in relationship to the wound care.
(See Attachment/s 12)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement for the nurse to regularly re-evaluate the patients nursing needs.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included requirement for the nurse to regularly re-evaluate the patients nursing needs.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N093 part 2

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 1.0: Scope Of Services
- Service Delivery 2.0: Admissions/Client Assessment
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal and state regulations.
(See Attachment S1, S2, S14)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement for the completion of a comprehensive assessment utilizing the OASIS C guidance manual.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement for the completion of a comprehensive assessment utilizing the OASIS C guidance manual. (See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N096

Survey on site Plan of Correction 08/05/2014

At the time of survey, some identified issues were immediately addressed, with a plan of correction implemented and completed for the patient prior to the exit of the surveyors. These issues included:

- Lack of a current PT INR, last PT INR (of record) completed 5/12/2014. There was a PT INR completed in the physician's office on 7/22/2014.
- Lack of follow up to request of PT INR order requests.
- Medication list not consistent with medications in the home.
- Patient not consistently taking medications as prescribed.
- Patient expressed a lack of education to medications.
- Weight not completed at the visit. With lack of follow up to the reported weight that was obtained by the patient.
- Patient's current ordered frequency is insufficient to meet the patients current needs.

(See Attachment/s 17)

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 1.0: Scope Of Services
- Service Delivery 2.0: Admissions/Client Assessment
- Service Delivery 5.0: Coordination of Services
- Service Delivery 6.0: The Physician's Role
- Service Delivery 7.0: Medications
- Service Delivery 9.0: Laboratory Services
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal and state regulations.
(See Attachment S1, S2, S5, S6, S7, S9, S14)

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching
- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 6)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.

(See Attachment/s 11)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This inservicing included the requirement to initiate appropriate preventative and rehabilitative nursing procedures.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement to initiate appropriate preventative and rehabilitative nursing procedures.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed and the onsite supervisory visits that are completed with the staff members. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N097

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 5.0: Coordination of Services
- Service Delivery 6.0: The Physician's Role
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal and state regulations.
(See Attachment S5, S6, S14)

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching
- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 6)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/15/2014

Inservicing occurred by Michele Carr, DPM, Clinical Operations Consultant did inservicing in relationship to wound care, the documentation of the wound care, the follow up needs to the wound care and care coordination needs in relationship to the wound care.
(See Attachment/s 12)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement for coordination of care, when coordination of care should occur, who the coordination of care should occur with, and follow up when the coordination has occurred.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement for coordination of care, when coordination of care should occur, who the coordination of care should occur with, and follow up when the coordination has occurred.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N098

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 5.0: Coordination of Services
- Service Delivery 6.0: The Physician's Role
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal and state regulations.
(See Attachment S5, S6, S14)

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching
- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 6)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/15/2014

Inservicing occurred by Michele Carr, DPM, Clinical Operations Consultant did inservicing in relationship to wound care, the documentation of the wound care, the follow up needs to the wound care and care coordination needs in relationship to the wound care.
(See Attachment/s 12)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement for coordination of care, when coordination of care should occur, who the coordination of care should occur with, and follow up when the coordination has occurred.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement for coordination of care, when coordination of care should occur, who the coordination of care should occur with, and follow up when the coordination has occurred.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N108

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 14.0: Clinical Records
- Service Delivery 22.0: Wound/Ulcer Assessment and Management

were completed to confirm compliance to federal and state regulations.
(See Attachment S14, S22)

Employee Intervention 08/11/2014

The LPN's employment was terminated due to lack of documentation and not responding to requests from Agency Director for clarification regarding her documentation.

(See Attachment/s 1)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/15/2014

Inservicing occurred by Michele Carr, DPM, Clinical Operations Consultant did inservicing in relationship to wound care, the documentation of the wound care, the follow up needs to the wound care and care coordination needs in relationship to the wound care.
(See Attachment/s 12)

Inservice 8/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This inservicing included the requirement to assure that the plan of care or additional orders are followed, and that documentation related to the assessment, tasks, education, and other patient related activities are appropriately documented and reported to the patients case manager.
(See Attachment/s 13)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N122

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Personnel 2.0: Home Health Aide Competency and Supervision
- Service Delivery 2.0: Admissions/Client Assessment

were completed to confirm compliance to federal and state regulations.
(See Attachment P2, S2)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4.9)

Inservice 08/13/2014

The Agency Director, Kimberly Lake RN and the Clinical Operations Consultant, Tracy Russell LPN, met with the Home Health Aide to discuss the requirement for a home health aide plan of care prior to providing any care for the patient. It was also discussed the need to notify the case manager of any requests for alterations to the plan of care. The Home Health Aide is to notify the Agency Director if a Home Health Aide plan of care is not completed prior to a scheduled visit or if needed alterations to the plan of care are not completed in a timely manner.
(See Attachment/s 7)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care

- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement to assure that all patients receiving HHA services has a plan of care completed prior to any scheduled visits.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement to assure that all patients receiving HHA services has a plan of care completed prior to any scheduled visits.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N123

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 12.0 : Transfer and/or Discharge from Services

was completed to confirm compliance to federal and state regulations.
(See Attachment S12)

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching
- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 6)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4,9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 09/04/2014

An inservice was completed with all staff to assure the understanding of the requirements when discharging from a discipline or from Home Health Services.
(See Attachment/s 18)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N138

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy

- Personnel 1.0: Professional Personnel competency and Supervision

was completed to confirm compliance to federal and state regulations.
(See Attachment P1)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s **4, 9**)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Medicare 101", the specifics regarding the Medicare Benefit, and HIPPA
(See Attachment/s 10)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/15/2015

A Conference Call was completed to address the Medical Social services potential deficiency. The following plan was discussed with the staff voicing understanding.

- Orders for social services will be obtained by physician order to include social services frequency and duration.

-This information will be forwarded to the HH POC/485

- A request will be made to the HCHB data system to provide a Coordination Note type that would allow for a report to be produced that would account for all patients receiving LSW intervention and subsequent documentation with MSW oversight. This would provide accountability of the MSW supervision and increase efficiency in the ongoing auditing process.
- No less than weekly, the MSW will show his/her involvement in the home health patient's care as evidenced by: review of and signature on visit notes and social work evaluations. Changes to the patient's home health plan of care will be noted by the MSW in the patient's medical record via a Coordination Note. A copy of the completed list of patients receiving MSW oversight will be emailed to the Branch Director, the Regional Administer, and the LSWs until a new Coordination Note type can be implemented (see previous bullet point).
- On a weekly basis the Branch Director or their designee will confirm that all evaluations completed the previous week by the LSW has supervision documentation completed by the MSW, and that supervision is contained within the patient's electronic record. Any noncompliance will immediately be addressed with the MSW and copied to the Administrator and Regional Vice President for additional follow up.
- No less than monthly and as needed, a telephone call will be conducted between the MSW and the social work assistant to discuss the social work assistant's caseload, any immediate patient concerns and the projected needs of current patients.
- Following the monthly call, an email will be generated by the MSW and sent to the Branch Director documenting that oversight of the social work assistant has occurred by identification of patients with immediate needs/concerns. This electronic record will be printed and filed in a binder by the Branch Director, as well as, electronically archived. The Clinical Consultant will complete routine audits to ensure that documentation of these supervisory calls are being appropriately maintained.

(See Attachment/s 19)

Follow up:

- Compliance will be immediate and ongoing
- 10% of records with patients receiving social work services will be reviewed for 3 months or until 90% compliance has been achieved. Then 5% of patient records will be reviewed to ensure continued compliance for a total of 1 year.
- Compliance will be monitored by Clinical Field Staff Supervisor and Branch Director

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Allegation of Compliance Date: 09/22/2014

N139

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy

- Personnel 1.0: Professional Personnel competency and Supervision

was completed to confirm compliance to federal and state regulations.
(See Attachment P1)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Medicare 101", the specifics regarding the Medicare Benefit, and HIPPA
(See Attachment/s 10)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/15/2015

A Conference Call was completed to address the Medical Social services potential deficiency. The following plan was discussed with the staff voicing understanding.

- Orders for social services will be obtained by physician order to include social services frequency and duration.

-This information will be forwarded to the HH POC/485

- A request will be made to the HCHB data system to provide a Coordination Note type that would allow for a report to be produced that would account for all patients receiving LSW intervention and subsequent documentation with MSW oversight. This would provide accountability of the MSW supervision and increase efficiency in the ongoing auditing process.
- No less than weekly, the MSW will show his/her involvement in the home health patient's care as evidenced by: review of and signature on visit notes and social work evaluations. Changes to the patient's home health plan of care will be noted by the MSW in the patient's medical record via a Coordination Note. A copy of the completed list of patients receiving MSW oversight will be emailed to the Branch Director, the Regional Administer, and the LSWs until a new Coordination Note type can be implemented (see previous bullet point).
- On a weekly basis the Branch Director or their designee will confirm that all evaluations completed the previous week by the LSW has supervision documentation completed by the MSW, and that supervision is contained within the patient's electronic record. Any noncompliance will immediately be addressed with the MSW and copied to the Administrator and Regional Vice President for additional follow up.
- No less than monthly and as needed, a telephone call will be conducted between the MSW and the social work assistant to discuss the social work assistant's caseload, any immediate patient concerns and the projected needs of current patients.
- Following the monthly call, an email will be generated by the MSW and sent to the Branch Director documenting that oversight of the social work assistant has occurred by identification of patients with immediate needs/concerns. This electronic record will be printed and filed in a binder by the Branch Director, as well as, electronically archived. The Clinical Consultant will complete routine audits to ensure that documentation of these supervisory calls are being appropriately maintained.

(See Attachment/s 19)

Follow up:

- Compliance will be immediate and ongoing
- 10% of records with patients receiving social work services will be reviewed for 3 months or until 90% compliance has been achieved. Then 5% of patient records will be reviewed to ensure continued compliance for a total of 1 year.
- Compliance will be monitored by Clinical Field Staff Supervisor and Branch Director

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Allegation of Compliance Date: 09/22/2014

N152

On Site Plan of Correction 08/05/2014

At the time of survey, some identified issues were immediately addressed, with a plan of correction implemented and completed for the patient prior to the exit of the surveyors. These issues included:

- Lack of a current PT INR, last PT INR (of record) completed 5/12/2014. There was a PT INR completed in the physician's office on 7/22/2014.
- Lack of follow up to request of PT INR order requests.
- Medication list not consistent with medications in the home.
- Patient not consistently taking medications as prescribed.
- Patient expressed a lack of education to medications.
- Weight not completed at the visit. With lack of follow up to the reported weight that was obtained by the patient.
- Patient's current ordered frequency is insufficient to meet the patients current needs.

(See Attachment/s 17)

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 1.0: Scope Of Services
- Service Delivery 2.0: Admissions/Client Assessment
- Service Delivery 5.0: Coordination of Services
- Service Delivery 6.0: The Physician's Role
- Service Delivery 7.0: Medications
- Service Delivery 9.0: Laboratory Services
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal and state regulations.
(See Attachment S1, S2, S5, S6, S7, S9, S14)

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching
- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 6)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Medicare 101", the specifics regarding the Medicare Benefit, and HIPPA
(See Attachment/s 10)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement for development of the plan of care, following the plan of care, documentation of assessments and interventions, follow up to issues identified, and updating the plan of care as needed.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement for development of the plan of care, following the plan of care, documentation of assessments and interventions, follow up to issues identified, and updating the plan of care as needed.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. The packet review nurse that reviews the POC at admission, resumption and recertification will provide education related to areas requiring improvement or when an area of non-compliance is identified. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N155

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 1.0: Scope Of Services
- Service Delivery 2.0: Admissions/Client Assessment

were completed to confirm compliance to federal and state regulations.
(See Attachment S1, S2)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement for assuring the accuracy of the plan of care in reflecting the patients 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 and any safety measures to protect against injury, instructions for timely discharge or referral and any other appropriate items.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement for assuring the accuracy of the plan of care in reflecting the patients 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 and any safety measures to protect against injury, instructions for timely discharge or referral and any other appropriate items.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. The packet review nurse that reviews the POC at admission, resumption and recertification will provide education related to areas requiring improvement or when an area of non-compliance is identified. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and

quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N161

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 1.0: Scope Of Services
- Service Delivery 2.0: Admissions/Client Assessment

were completed to confirm compliance to federal and state regulations.
(See Attachment S1, S2)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement for assuring the accuracy of the plan of care in reflecting the patients 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 and any safety measures to protect against injury, instructions for timely discharge or referral and any other appropriate items.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement for assuring the accuracy of the plan of care in reflecting the patients 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 and any safety measures to protect against injury, instructions for timely discharge or referral and any other appropriate items.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. The packet review nurse that reviews the POC at admission, resumption and recertification will provide education related to areas requiring improvement or when an area of non-compliance is identified. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and

quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N170

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy:

- Service Delivery 2.0: Admissions/Client Assessment

was completed to confirm compliance to federal and state regulations.
(See Attachment S2)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This inservicing included the requirement to receive a verbal order to approve the proposed plan of care after admission, recertification or resumption. The documentation of the verbal order is maintained on the POC order as the "attestation statement".
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement to receive a verbal order to approve the proposed plan of care after admission, recertification or resumption. The documentation of the verbal order is maintained on the POC order as the "attestation statement".
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N172

Survey on site Plan of Correction 08/05/2014

At the time of survey, some identified issues were immediately addressed, with a plan of correction implemented and completed for the patient prior to the exit of the surveyors. These issues included:

- Lack of a current PT INR, last PT INR (of record) completed 5/12/2014. There was a PT INR completed in the physician's office on 7/22/2014.
- Lack of follow up to request of PT INR order requests.
- Medication list not consistent with medications in the home.
- Patient not consistently taking medications as prescribed.
- Patient expressed a lack of education to medications.
- Weight not completed at the visit. With lack of follow up to the reported weight that was obtained by the patient.
- Patient's current ordered frequency is insufficient to meet the patients current needs.

(See Attachment/s 17)

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 5.0: Coordination of Services
- Service Delivery 6.0: The Physician's Role
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal and state regulations.
(See Attachment S5, S6, S14)

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching

- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 6)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4, 9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
- Following the written plan of care
- Consistency of Documentation
- Review of patient's medication list
- Requirements of a visit

(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.
(See Attachment/s 11)

Inservice 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement for coordination of care, when coordination of care should occur, who the coordination of care should occur with, and follow up when the coordination has occurred.
(See Attachment/s 13)

A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement for coordination of care, when coordination of care should occur, who the coordination of care should occur with, and follow up when the coordination has occurred.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

N173

Survey on site Plan of Correction 08/05/2014

At the time of survey, some identified issues were immediately addressed, with a plan of correction implemented and completed for the patient prior to the exit of the surveyors. These issues included:

- Lack of a current PT INR, last PT INR (of record) completed 5/12/2014. There was a PT INR completed in the physician's office on 7/22/2014.
- Lack of follow up to request of PT INR order requests.
- Medication list not consistent with medications in the home.
- Patient not consistently taking medications as prescribed.
- Patient expressed a lack of education to medications.
- Weight not completed at the visit. With lack of follow up to the reported weight that was obtained by the patient.
- Patient's current ordered frequency is insufficient to meet the patients current needs.

(See Attachment/s 17)

Plan 8/8/2014

A meeting of the management met to determine a plan to address probable deficiencies discussed with the surveyors at the time of the exit. A plan was developed to assure the proper training, inservicing, implementation and follow up to the identified issues.
(See Attachment/s 3)

Policy Review 08/09/2014

A review of policy/ies

- Service Delivery 1.0: Scope Of Services
- Service Delivery 2.0: Admissions/Client Assessment
- Service Delivery 5.0: Coordination of Services
- Service Delivery 6.0: The Physician's Role
- Service Delivery 7.0: Medications
- Service Delivery 9.0: Laboratory Services
- Service Delivery 14.0: Clinical Records

were completed to confirm compliance to federal and state regulations.
(See Attachment S1, S2, S5, S6, S7, S9, S14)

Inservice 08/07/2014

Inservicing occurred following Case Conference by Kimberly Lake RN, Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Medication reconciliation
- Medication teaching
- Medication list in the patient's home
- Following up with patient's prior and new issues
- Missed visits
- Coordination of Care
- Visit narrative
- Plan of Care synopsis

(See Attachment/s 6)

Inservice 08/11/2014

A meeting was conducted with all staff by Duke VanCampen, Regional Vice President and Randy Schellhous to discuss the survey findings discussed at the survey exit. The plan for special education inservicing planned for the staff throughout the next 6 weeks with focused inservicing planned for the weeks of 08/10/2014 and 8/17/2014. The plan to have one on one supervision of nursing visits, with follow up training was also discussed.

(See Attachment/s 4,9)

Inservice 08/14/2014

Inservicing occurred following Case Conference by Kimberly Agency Director, JoRae Thorne RN, PRQI and Tracy Russell Clinical Operations including:

- Coordination of Care
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(See Attachment/s 8)

Inservice 08/14/2014

Inservicing occurred by Julie Hardy, PT, Clinical Education Consultant regarding "Defensible Documentation". This inservicing was to assure the understanding of documentation requirements for Federal and State regulations.

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service 08/18/2014

Berith Kelm, RN, Clinical Operations Consultant provided inservicing regarding the nursing requirements from admission to discharge. This training included the requirement the review of medications and the reconciliation of the medications in coordination with the physician.
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A Clinical Post Test was completed by each clinician with assurance that all passed with at least 90% accuracy. All miss-answered questions were addressed on a one on one basis with the clinician during their individualized training.
(See Attachment/s 13)

Training 08/26/2014-08/27/2014

Individualized training was performed with each Case Manager. Part of this training included the requirement the review of medications and the reconciliation of the medications in coordination with the physician.
(See Attachment/s 15)

Follow up:

Compliance to this requirement will be monitored by the Agency Branch Director, or her designee, with the weekly chart audits that are completed. The Branch Director will also assure that this information is included as part of the orientation process of any new employees to assure ongoing understanding and implementation of this requirement. Monitoring for documentation of the provision of financial information to the patient at start of care will also be completed on a quarterly basis by Tracy Russell, the Clinical Operation Consultant. Assurance that these items are addressed during orientation and with weekly and quarterly audits will be reviewed by the Regional Administrator, Randy Schellhous with his onsite supervision.

Allegation of Compliance Date: 09/22/2014

PRINTED: 08/25/2014
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES 'D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	OAS001675		08/07/2014

NAME OF PROVIDER OR SUPPLIER: ENCOMPASS HOME HEALTH OF WESTERN ID

STREET ADDRESS, CITY, STATE, ZIP CODE: 433 S WHITLEY DR, 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 000	16.03.07 INITIAL COMMENTS A recertification survey was completed at Encompass Home Health of Western Idaho 8/04/14 though 8/07/14. Immediate jeopardy to a patient's health and safety was cited at tag G170 . The jeopardy was abated prior to the exit conference. The surveyors conducting the recertification were: Nancy Bax RN, BSN, HFS Team Lead Don Sylvester, RN, BSN, HFS Acronyms used in this report include: ALF - Assisted Living Facility BG - Blood Glucose CHF - Congestive Heart Failure CKD - Chronic Kidney Disease CM - Case Manager COPD - Chronic Obstructive Pulmonary Disease DM - Diabetes Mellitus DM II - Type 2 Diabetes Mellitus DME - Durable Medical Equipment HH - Home Health HHA - Home Health Aide HTN - Hypertension INR - International Normalized Ratio LPN - Licensed Practical Nurse Mg - Milligrams MSW - Masters of Social Work OASIS - Outcome and Assessment Information Set OT - Occupational Therapy POC - Plan of Care Pt - Patient PT - Physical Therapy RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care	N 000	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014 RECEIVED SEP 23 2014 FACILITY STANDARDS	09/04/2014

I of Facility Standards

ATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Regional Administrator | (X6) DATE: 9/2/14 9/4/2014

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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N 022	03.07020. ADM. GOV. BODY N022 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.iv. A patient has the right to confidentiality with regard to information about his health, social and financial circumstances and about what takes place in his home. This Rule is not met as evidenced by: Refer to G111	N 022	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 039	03.07020. ADMIN.GOV. BODY N039 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.xxi. Before the care is initiated, the HHA must inform a patient orally and in writing of the following: a) The extent to which payment may be expected from third party payors.; and This Rule is not met as evidenced by: Refer to G114	N 039	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 040	03.07020. ADMIN. GOV. BODY N040 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the	N 040	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

Bureau of Facility Standards

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N 040	Continued From page 2 following: d.xxi. Before the care is initiated, the HHA must inform a patient orally and in writing of the following: b) The charges for services that will not be covered by third party payors; and This Rule is not met as evidenced by: Refer to G114	N 040	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 041	03.07020. ADMIN. GOV. BODY N041 04. Patients' Rights. Insure that patients' rights are recognized and include as a minimum the following: d.xxi. Before the care is initiated, the HHA must inform a patient orally and in writing of the following: c) The charges that the patient may have to pay; and This Rule is not met as evidenced by: Refer to G114	N 041	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for:	N 062	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

Bureau of Facility Standards

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N 062	Continued From page 3 i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G143	N 062	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 091	03.07024. SK.NSG.SERV. N091. The HHA furnishes nursing services by or under the supervision of a registered nurse in accordance with the plan of care. This Rule is not met as evidenced by: Refer to G170	N 091	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 093	03.07024. SK. NSG. SERV. N093 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: a. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs; This Rule is not met as evidenced by: Refer to G172 and G331	N 093	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 096	03.07024. SK. NSG. SERV.	N 096	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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N 096	Continued From page 4 N096 01.Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: d. Initiates appropriate preventive and rehabilitative nursing procedures; This Rule is not met as evidenced by: Refer to G175	N 096	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 097	03.07024. SK. NSG. SERV. N097 01.Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: e. Prepares clinical and progress notes, and summaries of care; This Rule is not met as evidenced by: Refer to G176	N 097	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 098	03.07024. SK. NSG. SERV. N098 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A	N 098	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

Bureau of Facility Standards

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N 098	Continued From page 5 registered nurse performs the following: f. Informs the physician and other personnel of changes in the patient's condition and needs; This Rule is not met as evidenced by: Refer to G176	N 098	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 108	03.07024. SK. NSG. SERV. N108 02. Licensed Practical Nurse. A licensed practical nurse perform the following: f. Prepares clinical and progress notes, and This Rule is not met as evidenced by: Refer to G180	N 108	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
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 the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 123	03.07025.THERAPY SERV.	N 123	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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N 123	Continued From page 6 N123 025. THERAPY SERVICES. Any therapy services offered by the HHA directly or under arrangement are given by a qualified therapist or by a qualified therapy assistant under the supervision of a qualified therapist and in accordance with the plan of care. This Rule is not met as evidenced by: Refer to G185	N 123	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 138	03.07026.01.SOC.SERV. N138 01. Service Providers. If the agency furnishes medical social services, those services are given by a qualified social worker, licensed in Idaho, in accordance with the plan of care. This Rule is not met as evidenced by: Refer to G195	N 138	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 139	03.07026.02.SOC.SERV. N139 02. Social Worker. A social worker performs the following duties: a. Assists the physician and other team members in understanding the significant social and emotional factors related to health problems; This Rule is not met as evidenced by: Refer to G195	N 139	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 152	03.07030.01.PLAN OF CARE	N 152	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

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N 152	Continued From page 7 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 the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 155	03.07030. PLAN OF CARE N155 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: c. Types of services and equipment required; This Rule is not met as evidenced by: Refer to G159	N 155	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 161	03.07030.PLAN OF CARE N161 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: i. Medication and treatment	N 161	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

Bureau of Facility Standards

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N 161	Continued From page 8 orders; This Rule is not met as evidenced by: Refer to G159	N 161	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 170	03.07030.04.PLAN OF CARE N170 04. Initial Plan of Care. The initial plan of care and subsequent changes to the plan of care are approved by a doctor of medicine, osteopathy, or podiatric medicine. This Rule is not met as evidenced by: Refer to G160	N 170	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
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 the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for	N 173	Please see the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014

Bureau of Facility Standards

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N 173	Continued From page 9 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 the attached Plan of Correction with the date of alleged compliance noted as 09/22/2014	09/04/2014