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

CERTIFIED MAIL: 7007 3020 0001 4038 9956

November 15, 2013

Kerri Harpole, Administrator
Legacy Home Health
680 S Progress Avenue, Suite 2A
Meridian, ID 83642

RE: Legacy Home Health, Provider #137106

Dear Ms. Harpole:

Based on the survey completed at Legacy Home Health, on November 1, 2013, by our staff, we have determined Legacy Home Health is out of compliance with the Medicare Home Health Agency (HHA) **Condition of Participation of Acceptance of Patients, POC, Med Super (42 CFR 484.18)**. To participate as a provider of services in the Medicare Program, a HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

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

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

An acceptable Plan of Correction contains the following elements:

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

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

Such corrections must be achieved and compliance verified by this office, before December 16, 2013. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than December 4, 2013.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **November 27, 2013**.

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

We urge you to begin correetion immediately.

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

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/pt
Enclosures

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

November 24, 2013

Sylvia Creswell
Co-Supervisor
Non-Long Term Care

Gary Guiles
Health Facility Surveyor
Non-Long Term Care

Idaho Department of Health and Welfare
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83705

Re: Allegation of Compliance/Plan of Correction
Legacy Home Health, Provider #137106

Dear Ms. Creswell and Mr. Guiles,

Enclosed you will find our allegation of compliance/plan of correction in response to the survey conducted on November 1, 2013. We will have all components of the plan in place by December 4th. Please let us know if you require any further adjustments to our plan.

We appreciate the professionalism extended by your surveyors Gary Guiles, Suzi Costa, and Libby Doane while they were here.

Please let me know if you need any additional information.

Sincerely,

Kerri Harpole

Kerri Harpole RN, BSN
Legacy Home Health Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your home health agency completed 10/28/13 through 11/01/13. Surveyors conducting the survey were: Gary Guiles, RN, HFS - Team Leader Suzi Costa, RN, HFS Libby Doane, RN, BSN, HFS Acronyms used in this report include: A-Fib - Atrial Fibrillation ALF - Assisted Living Facility CAD - Coronary Artery Disease CHF - Congestive Heart Failure CVA - Cerebral Vascular Accident DM - Diabetes Mellitus DME - Durable Medical Equipment HTN - Hypertension lb - Pound mg - Milligrams ml - Milliliters POC - Plan of Care prn - as needed PT - Physical Therapy RN - Registered Nurse SOC - Start of Care SN - Skilled Nursing ST - Speech Therapist SW - Social Work TED hose - Thromboembolic deterrent stockings TPN - Total Parenteral Nutrition, feeding a person intravenously using dextrose, amino acids, lipids, vitamins, and minerals	G 000	RECEIVED NOV 27 2013 FACILITY STANDARDS	
G 143	484.14(g) COORDINATION OF PATIENT	G 143		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kari Hampare RN | TITLE: Administrator | (X6) DATE: 11/24/13

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 143	Continued From page 1 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 review of agency policies and agency and ALF patient records, staff interview, and home visit observation, it was determined the agency failed to ensure staff maintained liaison to ensure coordinated patient care for 3 of 17 patients (#6, #8, and #13) whose records were reviewed. This had the potential to adversely affect the quality and safety of patient care. Findings include: An agency policy, titled "COORDINATION OF PATIENT SERVICES," undated, stated "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care. This may be done through formal care conferences; maintaining complete, current Care Plans; and written and verbal interaction." This policy was not followed. Examples include: 1. Patient #6 was a 94 year old female who resided in an ALF. She was admitted to the agency on 4/02/13 for wound care. Patient #6's POC and medical record for the certification period 9/29/13 to 11/27/13 was reviewed. Her ALF medical record was also reviewed. Patient #6's POC included diagnoses of CHF, A-Fib, HTN and a venous stasis wound on her right foot. The POC included CHF monitoring for lower	G 143	See attached Plan of Correction.	

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G 143	Continued From page 2 extremity edema, use of tubigrip stockings on both lower legs, daily weights, and medication compliance. The POC included orders for Lasix 30 mg daily. Orders were signed by Patient #8's physician on 10/01/13. The orders included daily weights and to call the physician for weight gain of 3 pounds over 3 days or 5 pounds in 7 days. The order, also, included a prn order for Lasix 40 mg for 3 days for a weight gain greater than 3 pounds in 24 hours. The RN Case Manager did not coordinate Patient #6's care with the ALF to ensure the above orders were followed. The Patient #6's ALF medical record, and agency SN documentation, for the month of October, were reviewed and revealed the following: -10/01/13 - No weight was recorded. -10/02/13 - No weight was recorded. -10/03/13 - No weight was recorded. -10/04/13 - The ALF weight record noted Patient #6's weight of 104.3. An agency SN visit note documented Patient #6 was oxygen dependent. However, the note did not include further information related to oxygen use, such as liter flow, method of administration, or physician orders for the oxygen. -10/05/13 - The ALF weight record noted her weight of 105 pounds. -10/06/13 - The ALF weight record noted her weight of 105.1 pounds. -10/07/13 - No weight was recorded.	G 143		

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G 143	Continued From page 3 -10/08/13 - No weight was recorded. The RN Case Manager documented a missed visit note indicating a SN visit was missed because Patient #6 had wound clinic appointment. A communication note in Patient #6's agency medical record, documented by the RN Case Manager on 10/08/13, stated ALF staff informed her Patient #6 was on oxygen 2.5 liters per minute and her Lasix was increased from 30 mg to 40 mg daily. Patient #6's POC for the certification period 9/29/13 to 11/27/13, did not include orders for oxygen therapy. The RN Case Manager did not document receipt of physician orders or clarification with the ALF regarding orders for oxygen therapy for Patient #6. -10/09/13 - The ALF weight record noted Patient #6's weight of 110 pounds. There was no documentation the ALF reassessed Patient #6's weight to evaluate the 5 pound weight increase from three days before, or if the ALF had administered the additional Lasix as ordered for weight gain. -10/10/13 - No weight was recorded. -10/11/13 - The ALF weight record noted her weight of 104 pounds, and the home health SN visit note documented Patient #6 was on oxygen at 2 liters per minute. The nursing visit note did not include documentation the RN Case Manager identified and acted on the missed daily weights and the wide variances of Patient #6's weight. An agency care conference team meeting note, dated 10/11/13, documented Patient #6 had been started on oxygen and was on 2.5 liters per minute. Patient #6's home health medical record did not contain a physician order for oxygen.	G 143		

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G 143	Continued From page 4 -10/12/13 - No weight was recorded. -10/13/13 - No weight was recorded. -10/14/13 - The ALF weight record noted her weight of 106 pounds. An agency SN visit note documented Patient #6's Lasix was increased to 60 mg daily for 7 days, and she would be re-evaluated during a follow-up visit to the clinic on 10/17/13. -10/15/13 - The ALF weight record noted her weight of 106 pounds. -10/16/13 - The ALF weight record noted her weight of 106.4 pounds. -10/17/13 - The ALF weight record noted her weight of 110 pounds. The ALF medication sheet documented Lasix was increased to 60 mg daily without an end date of 7 days. A 10/17/13 agency communication note, documented by the RN Case Manager, indicated Patient #6 was on oxygen at 2.0 liters per minute continuously. The agency SN visit note documented Patient #6 had increased weight gain and edema, the Lasix 60 mg dose for 7 days had been completed, and she was to return to the Lasix dose of 40 mg daily. -10/18/13 - The ALF noted her weight of 110.2 pounds. -10/19/13 - No weight was recorded. -10/20/13 - The ALF noted her weight of 110 pounds. -10/21/13 - No weight was recorded. The SN visit	G 143		

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G 143	Continued From page 5 note did not document Patient #6's weight, but stated she complained of heavy and swollen legs. The SN noted the ALF RN was not available to speak with her that morning so she could not follow up with her regarding the results of Patient #6's most recent physician appointment. There was no documentation in the note that the ALF medication record was reviewed. -10/22/13 - No weight was recorded. -10/23/13 - No weight was recorded. -10/24/13 - No weight was recorded by the ALF. The RN Case Manager documented in a SN visit note that the ALF med tech informed her there was no weight gain in the past week, although the facility MAR indicated no weights had been obtained since 10/20/13. Additionally, the SN visit note documented Patient #6 was concerned that the edema to both her legs had not decreased. There was no documentation in the SN visit note that the ALF medication record was reviewed. -10/25/13 - No weight was recorded. -10/26/13 - The ALF noted her weight of 105 pounds. -10/27/13 - The ALF noted her weight of 112 pounds, indicating Patient #6 had a weight gain of 7 pounds in 24 hours. The ALF medication record did not document the administration of additional Lasix as ordered for weight gain. -10/28/13 - No weight was recorded. -10/29/13 - The ALF noted her weight of 120 pounds, indicating Patient #6 had a weight gain of	G 143		

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G 143	Continued From page 6 8 pounds in 2 days. The ALF medication record did not document the administration of additional Lasix as ordered for weight gain. -10/30/13 - The ALF noted her weight of 118 pounds. -10/31/12, No weight was recorded. At 10:30 AM during a home visit, the RN Case Manager was observed as she provided wound care for Patient #6. The RN Case Manager spoke briefly with the ALF RN and requested a copy of Patient #6's medication record. The RN Case Manager stated the ALF staff was responsible for obtaining and recording Patient #6's daily weights. She stated the facility was not consistent and showed the dates on the record that no weights had been recorded. Before Patient #6 was seen that morning, the RN Case Manager and the ALF RN reviewed Patient #6's weights on the medication record. The ALF RN stated it appeared as if the weekend staff were not consistant with obtaining weights. She did not offer further information such as an inquiry to her ALF staff of why the weights were not done on a daily basis. The RN Case Manager confirmed Patient #6 had weight fluctuations during the month of October with a range from 104 pounds to 120 pounds. The RN Case Manager did not review the ALF medication sheet to see if Patient #6 had received prn Lasix as ordered for weight gain. The HHA did not ensure all personnel, including ALF staff, coordinated efforts to monitor and treat Patient #6's CHF. 2. Patient #8 was an 83 year old male admitted to the agency on 10/06/13, for care primarily related to a stroke. A "COMMUNICATION/PHYSICIAN	G 143		

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G 143	Continued From page 7 ORDER," dated 10/16/13, requested the physician discontinue Reglan, which was ordered as 10 mg, 4 times daily. The communication to the physician stated Patient #8 had not been taking the medication as it caused stomach burning. The order to discontinue the medication was signed by Patient #8's physician and faxed back to the agency on 10/21/13. During an interview on 10/31/13 beginning at 2:45 PM, the agency Administrator stated the "COMMUNICATION/PHYSICIAN ORDER" was a request for an order. She stated the request was sent to the physician, signed, returned to the agency, and recorded as an order. Until the physician signed the form, it remained a communication to the physician, not an order. An ST visit note, dated 10/22/13 at 9:45 AM, documented that on 10/20/13 Patient #9's family had administered 7.5 mg of Reglan three times a day in an attempt to improve his speaking. The ST note stated improvement was noted on her 10/21/13 visit. The frequency and dose of Reglan Patient #8 had received differed from the original ordered dose of 10 mg 4 times daily. There was no documentation of coordination with the physician or RN Case Manager to restart the medication or to change the original dosage and frequency. The ST did not document communication with the RN Case Manager regarding Patient #8's medication change. During an interview on 10/31/13 beginning at 2:45 PM, the agency Administrator reviewed Patient #8's record and confirmed there was no communication between the RN Case Manager and the ST to clarify the status of the Reglan.	G 143		

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G 143	Continued From page 8 Patient #8's medication changes were not effectively coordinated. 3. Patient #13's medical record documented a 78 year old male admitted to the agency on 9/20/13 with diagnoses of after care following a vertebral fracture, lumbago, weight loss, depressive disorder, and chronic pain syndrome. His medical record and POC for the certification period of 9/20/13 through 11/18/13 was reviewed. Patient #13 was receiving SN, PT and SW services. The POC included grab bars as DME and supplies needed to care for Patient #13. The SOC assessment, completed 9/20/13, also documented grab bars as DME and supplies. However, a SW visit note, dated 10/07/13 at 10:50 AM, documented Patient #13 was "in need of some adaptive equiptment [sic] such as toilet seat riser and grab bars in his restroom." A SW visit note, dated 10/15/13 at 9:46 AM, documented "informed PT that [patient] is using towel rack as grab bar. PT states he will have neighbor take him to purchase toilet seat riser." A SW visit note, dated 10/22/13 at 9:33 AM, documented "did talk with PT regarding not yet having a toilet seat riser & continued use of towel rack as a grab bar." The Physical Therapist providing care to Patient #13 was interviewed by speaker phone on 11/01/13 with the Administrator present. He confirmed Patient #13 did not have grab bars in the the home. He stated his recommendation was for one grab bar in the shower but it was not imperative that Patient #13 have it. In addition,	G 143		

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G 143	Continued From page 9 he stated he did not recommend a toilet seat riser for Patient #13, but had not coordinated with the SW on this matter. The Administrator reviewed the record and confirmed that care had not been coordinated between the Social Worker and Physical Therapist in relation to Patient #13's DME needs. Care was not coordinated in relation to DME.	G 143		
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on staff interview, observation, and review of medical records, it was determined the agency failed to ensure care followed a written POC and POCs included all pertinent information necessary to direct care. This resulted in patients' not receiving care consistent with their POCs and a lack of direction to agency personnel to ensure needed care was provided. Findings include: 1. Refer to G158 as it relates to the agency's failure to ensure patient care followed a written POC. 2. Refer to G159 as it relates to the agency's failure to ensure POCs covered all pertinent diagnoses and equipment. The cumulative effect of these negative systemic practices impeded the agency in providing quality care in accordance with established POCs.	G 156	See attached Plan of Correction.	

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G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review, observation, and staff interview, it was determined the facility failed to ensure care followed a written plan of care for 4 of 17 patients (#1, #6, #13, and #14) whose records were reviewed. This resulted in medical equipment that was not provided, inconsistent patient weight monitoring, missed blood glucose monitoring, medication administration without an order, medications not administered and additional therapy visits that were not ordered. Findings include: 1. Patient #6 was a 94 year old female who resided in an ALF. She was admitted to the agency on 4/02/13 for wound care. Patient #6's POC and medical record for the certification period 9/29/13 to 11/27/13 was reviewed. Her ALF medical record was also reviewed. Patient #6's POC included diagnoses of CHF, A-Fib, HTN and a venous stasis wound on her right foot. The POC included CHF monitoring for lower extremity edema, use of tubigrip stockings on both lower legs, daily weights, and medication compliance. The POC included orders for Lasix 30 mg daily. Orders were signed by Patient #8's physician on 10/01/13. The orders included daily weights and to call the physician for weight gain of 3 pounds over 3 days or 5 pounds in 7 days. The order, also, included a prn order for Lasix 40 mg for 3 days for a weight gain greater than 3 pounds in 24 hours.	G 158	See attached Plan of Correction.	

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G 158	Continued From page 11 The Patient #6's ALF medical record, and agency SN documentation, for the month of October, were reviewed and revealed the following: -10/01/13 - No weight was recorded. -10/02/13 - No weight was recorded. -10/03/13 - No weight was recorded. -10/04/13 - The ALF weight record noted Patient #6's weight of 104.3. An agency SN visit note documented Patient #6 was oxygen dependent. However, the note did not include further information related to oxygen use, such as liter flow, method of administration, or physician orders for the oxygen. -10/05/13 - The ALF weight record noted her weight of 105 pounds. -10/06/13 - The ALF weight record noted her weight of 105.1 pounds. -10/07/13 - No weight was recorded. -10/08/13 - No weight was recorded. The RN Case Manager documented a missed visit note indicating a SN visit was missed because Patient #6 had wound clinic appointment. A communication note in Patient #6's agency medical record, documented by the RN Case Manager on 10/08/13, stated ALF staff informed her Patient #6 was on oxygen 2.5 liters per minute and her Lasix was increased from 30 mg to 40 mg daily. Patient #6's POC for the certification period 9/29/13 to 11/27/13, did not include orders for oxygen therapy. The RN Case	G 158		

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	137106	A. BUILDING _____ B. WING _____	11/01/2013

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G 158	Continued From page 12 Manager did not document receipt of physician orders or clarification with the ALF regarding orders for oxygen therapy for Patient #6. -10/09/13 - The ALF weight record noted Patient #6's weight of 110 pounds. There was no documentation the ALF reassessed Patient #6's weight to evaluate the 5 pound weight increase from three days before, or if the ALF had administered the additional Lasix as ordered for weight gain. -10/10/13 - No weight was recorded. -10/11/13 - The ALF weight record noted her weight of 104 pounds, and the home health SN visit note documented Patient #6 was on oxygen at 2 liters per minute. The nursing visit note did not include documentation the RN Case Manager identified and acted on the missed daily weights and the wide variances of Patient #6's weight. An agency care conference team meeting note, dated 10/11/13, documented Patient #6 had been started on oxygen and was on 2.5 liters per minute. Patient #6's home health medical record did not contain a physician order for oxygen. -10/12/13 - No weight was recorded. -10/13/13 - No weight was recorded. -10/14/13 - The ALF weight record noted her weight of 106 pounds. An agency SN visit note documented Patient #6's Lasix was increased to 60 mg daily for 7 days, and she would be re-evaluated during a follow-up visit to the clinic on 10/17/13. -10/15/13 - The ALF weight record noted her	G 158		

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G 158	Continued From page 13 weight of 106 pounds. -10/16/13 - The ALF weight record noted her weight of 106.4 pounds. -10/17/13 - The ALF weight record noted her weight of 110 pounds. The ALF medication sheet documented Lasix was increased to 60 mg daily without an end date of 7 days. A 10/17/13 agency communication note, documented by the RN Case Manager, indicated Patient #6 was on oxygen at 2.0 liters per minute continuously. The agency SN visit note documented Patient #6 had increased weight gain and edema, the Lasix 60 mg dose for 7 days had been completed, and she was to return to the Lasix dose of 40 mg daily. -10/18/13 - The ALF noted her weight of 110.2 pounds. -10/19/13 - No weight was recorded. -10/20/13 - The ALF noted her weight of 110 pounds. -10/21/13 - No weight was recorded. The SN visit note did not document Patient #6's weight, but stated she complained of heavy and swollen legs. The SN noted the ALF RN was not available to speak with her that morning so she could not follow up with her regarding the results of Patient #6's most recent physician appointment. There was no documentation in the note that the ALF medication record was reviewed. -10/22/13 - No weight was recorded. -10/23/13 - No weight was recorded.	G 158		

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G 158	Continued From page 14 -10/24/13 - No weight was recorded by the ALF. The RN Case Manager documented in a SN visit note that the ALF med tech informed her there was no weight gain in the past week, although the facility MAR indicated no weights had been obtained since 10/20/13. Additionally, the SN visit note documented Patient #6 was concerned that the edema to both her legs had not decreased. There was no documentation in the SN visit note that the ALF medication record was reviewed. -10/25/13 - No weight was recorded. -10/26/13 - The ALF noted her weight of 105 pounds. -10/27/13 - The ALF noted her weight of 112 pounds, indicating Patient #6 had a weight gain of 7 pounds in 24 hours. The ALF medication record did not document the administration of additional Lasix as ordered for weight gain. -10/28/13 - No weight was recorded. -10/29/13 - The ALF noted her weight of 120 pounds, indicating Patient #6 had a weight gain of 8 pounds in 2 days. The ALF medication record did not document the administration of additional Lasix as ordered for weight gain. -10/30/13 - The ALF noted her weight of 118 pounds. -10/31/12 - No weight was recorded. On 10/31/13 at 10:30 AM, during a home visit, the RN Case Manager was observed as she provided wound care for Patient #6. The RN Case Manager spoke briefly with the ALF RN and requested a copy of Patient #6's medication	G 158		

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G 158	Continued From page 15 record. The RN Case Manager stated the ALF staff was responsible for obtaining and recording Patient #6's daily weights. She stated the facility was not consistent and showed the dates on the record that no weights had been recorded. Before Patient #6 was seen that morning, the RN Case Manager and the ALF RN reviewed Patient #6's weights on the medication record. The ALF RN stated it appeared as if the weekend staff were not consistant with obtaining weights. She did not offer further information such as an inquiry to ALF staff of why the weights were not done on a daily basis. The RN Case Manager confirmed Patient #6 had weight fluctuations during the month of October with a range from 104 pounds to 120 pounds. The RN Case Manager did not review the ALF medication sheet to see if Patient #6 had received prn Lasix as ordered for weight gain. Patient #6 was not weighed daily as stated in her POC. She did not receive the prn Lasix ordered to be given when her weight gain exceeded the parameters identified in her POC. Patient #6 also received oxygen when it was not included on her POC. 2. Patient #1's medical record documented a 64 year old female who was admitted for home health care on 10/22/13 and was currently a patient as of 11/01/13. She was admitted following surgery to treat an abdominal abscess. Other diagnoses included type II diabetes and obesity. A "HISTORY AND PHYSICAL," dated 10/02/13, stated Patient #1 took Metformin, an oral hypoglycemic medication, to control her diabetes. At the time, she did not take insulin. Patient #1's POC for the certification period of	G 158		

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G 158	Continued From page 16 10/22/13 to 12/20/13, called for the nurse to assess for "diabetic complications" and listed "glucometer," a device to measure blood sugar, under the heading "DME and Supplies." The RN Case Manager for Patient #1 was interviewed on 10/30/13 beginning at 8:35 AM. She stated Patient #1 did not have a glucometer and her blood sugar levels had not been checked since her admission. Patient #1 was not provided with a glucometer to check her blood sugar, as ordered on the POC. 3. Patient #13's medical record documented a 78 year old male admitted to the agency on 9/20/13 with diagnoses of after care following a vertebral fracture, lumbago, weight loss, depressive disorder, and chronic pain syndrome. His medical record and POC for the certification period of 9/20/13 through 11/18/13 was reviewed. Patient #13 was receiving SN, PT and SW services. Patient #13's POC included grab bars as DME and supplies needed to care for Patient #13. The SOC assessment, completed 9/20/13, also documented grab bars as DME and supplies. However, a SW visit note, dated 10/07/13 at 10:50 AM, documented Patient #13 was "in need of some adaptive equiptment [sic] such as toilet seat riser and grab bars in his restroom." A SW visit note, dated 10/15/13 at 9:46 AM, documented "informed PT that [patient] is using towel rack as grab bar. PT states he will have neighbor take him to purchase toilet seat riser." A SW visit note, dated 10/22/13 at 9:33 AM,	G 158		

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G 158	Continued From page 17 documented "did talk with PT regarding not yet having a toilet seat riser & continued use of towel rack as a grab bar." The Physical Therapist providing care to Patient #13 was interviewed by speaker phone on 11/01/13 at 2:00 PM with the Administrator present. He confirmed Patient #13 did not have grab bars in the the home. He stated his recommendation was for one grab bar in the shower but it was not imperative that Patient #13 have it. In addition, he stated he did not recommend a toilet seat riser for Patient #13, but had not communicated that with the SW. The Administrator reviewed the record and confirmed that although grab bars were listed on the POC as DME and supplies, documentation provided by the SW and the interview with the Physical Therapist indicate Patient #13 did not actually have grab bars. Grab bars were not provided to Patient #13 in accordance with the POC. 4. Patient #14 was a 92 year old male who was admitted to the agency on 9/21/13, for therapy services related to muscle weakness, dementia, and osteoarthritis. His POC for the certification period 9/21/13 to 11/19/13, included orders for PT 1 time a week for the first week, 3 times a week for the second and third weeks, and 2 times a week for weeks 4 and 5. However, Patient #14's record included documentation of 3 visits conducted during weeks 4 and 5, although only 2 visits each week were ordered. Patient #14's medical record contained a request by the Physical Therapist, for 3 PT visits for weeks 4 and 5, dated 10/07/13, and faxed to the physician	G 158		

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G 158	Continued From page 18 10/23/13. The request was not signed by the physician as an order as of 10/31/13. During an interview on 10/31/13 beginning at 3:15 PM, the Administrator reviewed Patient #14's record. The Administrator confirmed the request for additional visits was not obtained as a verbal order and had not yet been authorized by the physician. PT visits were completed without an order.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the agency failed to ensure all pertinent diagnoses, ordered visits, and equipment were included for 5 of 17 patients (#1, #3, #11, #13, and #17) whose records were reviewed. This resulted in incomplete POCs and a lack of direction to staff as to how to care for patients. Findings include: 1. Patient #1's medical record documented a 64 year old female admitted for home health care on 10/22/13, and was currently a patient as of	G 159	See attached Plan of Correction.	

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G 159	Continued From page 19 11/01/13. She was admitted following surgery to treat an abdominal abscess. Other diagnoses included type II diabetes and obesity. A "HISTORY AND PHYSICAL," dated 10/02/13, stated Patient #1 took Metformin, an oral hypoglycemic medication, to control her diabetes. At the time, she did not take insulin. Patient #1's POC for the certification period 10/22/13-12/20/13 stated she was to receive TPN daily and continuously. The POC also stated Patient #1 was to take a long acting insulin 2 times a day. The POC called for the nurse to assess Patient #1's "diabetic complications" but it did not specify how often her blood sugar levels should be checked. The POC also listed "glucometer," a device to measure blood sugar, under the heading "DME and Supplies." Nursing visits to Patient #1 were documented on 10/22/13, 10/23/13, 10/24/13, 10/25/13, and 10/28/13. None of the visit notes documented Patient #1's blood sugar levels. The RN Case Manager for Patient #1 was interviewed on 10/30/13 beginning at 8:35 AM. She stated Patient #1 did not have a glucometer and her blood sugar levels had not been checked since her admission. She confirmed Patient #1 was receiving TPN and insulin. She confirmed the POC did not address Patient #1's need to monitor her blood sugar levels. Patient #1's POC did not cover her diabetes and the need to monitor her blood sugar levels. 2. Patient #17's medical record documented a 46 year old female admitted for home health care 5/07/13, and was discharged on 9/16/13. She	G 159		

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G 159	Continued From page 20 was admitted to manage extreme lymphedema in her legs. Other diagnoses included type II diabetes and chronic obstructive asthma. Patient #17's POC for the certification period 5/07/13-7/05/13 stated she was to take Metformin daily. The POC stated "ASSESS AS NEEDED:...diabetic status." The POC did not clarify what this meant and did not direct staff to monitor Patient #17's blood sugar levels. A "PATIENT MEDICATION SHEET," not dated, stated the Metformin was discontinued on 6/07/13 and Patient #17 was placed on Byetta, an injectable medication, to control her blood sugar. Patient #17's "NURSE RECERTIFICATION," dated 7/03/13, stated "Pt still has not started new Byetta Injections to manage DM d/t irregular meals. Instructed on new med and to notify MD if she decides not to start." A "COMMUNICATION NOTE," dated 7/11/13 at 3:59 PM, stated "Pt still has not started Byetta Injections to manage DM." A "COMMUNICATION/PHYSICIAN ORDER" from an RN to the physician, dated 9/05/13, stated Patient #17 still was not taking the Byetta. Patient #17's POC for the certification period 7/06/13-9/03/13 stated she was taking Byetta but it was on "hold." As before, the POC stated staff was to assess Patient #17's "Diabetic Status" but it did not define what this meant. Patient #17's medical record documented she was hospitalized from 8/21/13 to 8/30/13 for sepsis from a leg infection. Her resumption of care orders, dated 9/01/13, stated she was to take Byetta 2 times a day. Her POC for the certification period 9/04/13-11/02/13 stated she was to take Byetta 2 times a day but stated this	G 159		

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G 159	Continued From page 21 was on hold. Again the POC stated staff were to assess her "Diabetic Status" as needed. No documentation was present in Patient #17's medical record that her blood glucose levels had been checked while she was a patient of the home health agency. Patient #17's RN Case Manager was interviewed on 10/31/13 beginning at 10:35 AM. She reviewed Patient #17's medical record. She confirmed agency personnel had not documented any blood glucose levels. She stated Patient #17 was always sipping on regular sugared soda during home visits. She stated Patient #17 did not have a glucometer. She confirmed the POC did not address Patient #17's need to monitor her blood sugar levels. Patient #17's POC did not include all pertintent information related to her diabetes and the need to monitor her blood sugar levels. 3. Patient #3's medical record documented an 81 year old male admitted for home health care on 9/20/13, and was currently a patient as of 11/01/13. His primary diagnosis was type II diabetes. Patient #3's POC for the certification period 9/20/13-11/18/13 did not include hypoglycemic medication. His POC stated to assess his "Diabetic Status" as needed, but did not specify what that meant. The POC did not mention a glucometer. No blood sugar levels were documented in Patient #3's medical record as of 11/01/13.	G 159		

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G 159	Continued From page 22 The Administrator and Director of Clinical Services were interviewed together on 11/01/13 beginning at 2:25 PM. They reviewed Patient #3's medical record and both confirmed his POC did not address how staff would monitor his blood sugar levels. Patient #3's POC did not cover his diabetes and the need to monitor his blood sugar levels. 4. Patient #13's medical record documented a 78 year old male admitted to the agency on 9/20/13 with diagnoses of after care following a vertebral fracture, lumbago, weight loss, depressive disorder, and chronic pain syndrome. His medical record and POC for the certification period of 9/20/13 through 11/18/13 was reviewed. Patient #13 was receiving SN, PT and SW services. A "Referral Form," signed by the physician on 9/18/13, documented a referral to home health services for SN, SW, PT, home health aide, and "nutrition consult due to weight loss." Patient #13's POC documented "weight" under "PERFORM AS NEEDED." It was unclear what circumstances would require the RN to weigh Patient #13. The POC documented instructions to "ASSESS AS NEEDED" for "Fluid and Nutritional Status." It was unclear how fluid and nutritional status would be assessed. In addition, the POC documented a goal of "[Patient] will maintain adequate nutrition/hydration during this certification period." There was no documentation to indicate how this goal would be measured. The SOC assessment, dated 9/20/13,	G 159		

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G 159	Continued From page 23 documented Patient #13 was admitted for medication management, and nutrition assessment and teaching for a recent weight loss. It also documented Patient #13 had a 14 lb weight loss in 3 months, and his current stated weight was 146 lbs. The SOC also documented Patient #13 as "High risk" for nutritional problems, which indicated a need to "coordinate with physician, dietitian, social service professional or nurse about how to improve nutritional health." The RN documented the intervention as "SN to assess for community resources." It was unclear as to what this meant. There was no documentation in Patient #13's record to indicate the RN has assessed community resources to assist Patient #13. A nursing visit note, dated 9/30/13 at 2:48 PM, documented the RN encouraged Patient #13 to purchase a scale so his weight could be monitored. The RN also documented she reviewed importance of eating small frequent snacks and meals, and that Patient #13 showed her the dates and cereal he had been eating. A nursing visit note, dated 10/07/13 at 9:58 AM, documented the RN again encouraged Patient #13 to buy a scale so his weight could be monitored. There was no documentation of any further interventions related to Patient #13's nutritional status. A nursing visit note, dated 10/15/13 at 9:32 AM, documented the RN reminded Patient #13 again to buy a scale so "we can check weight." The RN also documented Patient #13 had "a good supply of food in his fridge and pantry today, but states his appetite is still not great." There was no documentation of further teaching or interventions	G 159		

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G 159	Continued From page 24 related to nutrition. A nursing visit note, dated 10/23/13 at 11:47 AM, documented "SN goals met; [Patient] reports pain control and better appetite, but remains forgetful, which poses challenges to further learning." The RN documented a stated weight of 136, a loss of 10 pounds from the SOC on 9/20/13. It was unclear where this number came from, as there was no documentation to indicate the RN had weighed Patient #13. It was unclear how the goal of "...maintain adequate nutrition/hydration ..." was met. The Administrator reviewed the record and was interviewed on 11/01/13 beginning at 1:40 PM. She stated the home health agency did not have a policy related to weighing patients. She stated staff encouraged patients to buy their own scales to have in the home, though she agreed this practice was not appropriate for Patient #13, as he was not able to supply himself with a scale. She confirmed the RN never weighed Patient #13 to assess for adequate nutritional intake, and the POC intervention of weigh patient as needed was unclear. In addition, she confirmed it was difficult to determine what education related to nutrition was given to Patient #13, other than eat several small meals a day. She confirmed it was difficult to determine how Patient #13 met the goal of "...maintain adequate nutrition/hydration...." Patient #13's POC lacked clear and complete information necessary to address his nutritional status. 5. Patient #11's medical record documented a 97 year old female admitted to the agency on 10/09/13 for treatment of a pressure ulcer. Her	G 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137106	A. BUILDING _____ B. WING _____	11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 159	Continued From page 25 diagnoses also include HTN and CHF. Her medical record for the certification period of 10/09/13 through 12/07/13 was reviewed. Nursing Visit notes dated 10/11/13, 10/18/13, 10/22/13, and 10/24/13, documented Patient #11 was wearing tubigrips, soft elastic compression stockings, to both legs. A nursing visit note, dated 10/15/13, documented Patient #11 was wearing TED hose, a different type of compression stocking, to both legs. However, neither TED hose nor tubigrips were included on the POC as DME or supplies. The Administrator reviewed the record and was interviewed on 11/01/13 beginning at 1:20 PM. She confirmed the tubigrips and TED hose were not included on the POC. Patient #11's POC did not include all DME and supplies.	G 159		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001310	A. BUILDING: _____ B. WING _____	11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the state licensing survey of your home health agency completed 10/28/13 through 11/01/13. Surveyors conducting the survey were: Gary Guiles, RN, HFS - Team Leader Suzi Costa, RN, HFS Libby Doane, RN, BSN, HFS	N 000	RECEIVED NOV 27 2013 FACILITY STANDARDS	
N 092	03.07024.01. SK.NSG.SERV. N092 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: This Rule is not met as evidenced by: Refer to G143 as it relates to the failure of the agency to ensure care was coordinated with agency staff and others.	N 092	See attached Plan of Correction.	
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by: Refer to G158 as it relates to the failure of the	N 152	See attached Plan of Correction.	

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

Kerri Happe RN — Administrator — 11/24/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001310	A. BUILDING: _____ B. WING _____	11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH	680 S PROGRESS AVENUE, SUITE 2A MERIDIAN, ID 83642

(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 152	Continued From page 1 agency to ensure care was furnished in accordance with the plan of care.	N 152		
N 153	03.07030.PLAN OF CARE N153 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: a. All pertinent diagnoses; This Rule is not met as evidenced by: Refer to G159 as it relates to the failure of the agency to ensure plans of care covered all pertinent information.	N 153	See attached Plan of Correction.	

Legacy Home Health Plan of Corrections

Deficiency Tag #	Provider's Plan of Correction	Individual Responsible for Compliance	Monitoring Frequency	Completion Date
G143 N092	Mandatory staff in-services have been completed and scheduled to review survey results and to provide continued education regarding effective communication between agency staff, ALF staff, physician, and patient/family, caregiver regarding any changes to Plan of Care, medication changes, or patient condition. This education includes emphasis on thorough documentation. A RN in-service was conducted on November 7th to include special instruction on disease management and teaching to patient, caregivers, and ALF staff (as it applies). RN's were instructed specifically on CHF & Diabetic patients including how to ensure that MD orders are being followed in the patients at home as well as those in ALF's. The nurses were instructed that they are responsible for coordinating with ALF staff to ensure MD orders are followed. If the patient has a change in condition, then it is mandatory that the nurse coordinates with the ALF staff to ensure MD orders are being followed properly. It is also the RN's responsibility to notify the MD of the change in condition in order to obtain pertinent orders as needed. The nurse is also responsible for the oversight of the ALF use of medications as ordered by MD. Any changes in medication must be updated on our MAR and if the patient's condition changes, then the case manager must coordinate with ALF Nurse to ensure that PRN medications are being used appropriately. Case managers were also instructed that they are also responsible for ensuring that weights on CHF patients are obtained and recorded as ordered. If the patient does not have a scale, then the agency RN must bring a scale and obtain weights on their visits, then notify the MD of patient inability to obtain weights, and coordinate with family, caregiver, physician, MSW, etc. to find community resources to obtain scale. If the patient resides in an ALF, then the RN must inquire of the weights obtained by ALF and assess the patient condition. If there is a weight gain/loss beyond parameters set by MD, then we must notify MD of changes. If a patient has a diagnosis of Diabetes then the RN must verify with the patient if they are checking blood sugars and if they have a glucometer. If they are not checking blood sugars, then the RN must clarify with the physician if they want blood sugars checked and the frequency. If the physician doesn't want the patient to check blood sugars then the nurse must obtain an order stating as such. If they do want them checked, then the RN must inquire of the blood sugar	Kerri Harpole, RN BSN Administrator Teri Bruha, RN Director of Clinical Services Janice Fountain, PT Rehabilitation Director	Ongoing Weekly & Quarterly Audits	December 3rd, 2013

	ranges at each visit. If the sugars are outside of parameters, then the physician must be notified. If the patient does not own a glucometer, then the nurse must check the blood sugar at each visit and notify the MD so that a prescription can be received for the patient to obtain one. In addition, Legacy has purchased glucometers and scales that are available to all the nurses to use while in the patient home. Staff has been and will continue to be educated to be realistic and specific with their plan of care and supplemental goals and they must be measureable. Contract ST was notified and educated regarding reading the MAR at each visit to see patient current medication list and to evaluate compliance and to inquire of any new medications or OTC's being used by the patient. If the patient reports any new medications, the ST must communicate with the case manager to coordinate communication with the physician regarding the change. The ST must also include any change in the patient's condition in this communication and document the discussion thoroughly in the patient's chart. At the mandatory staff in-service on November 19th, 2013, this was discussed in detail with the agency staff including the details of this deficiency to ensure thorough medication review, communication between peers, case manager, and physician will occur and the importance of documentation of such in the patients chart. Janice Fountain, PT Legacy's rehab director, will provide education to all contract therapy staff on these points.			
G156 G158 N152	Mandatory staff meetings/in-services have been completed and scheduled to review survey results and to provide continued education regarding effective communication between our staff, ALF staff, physician, and patient/family, caregiver regarding any changes to Plan of Care, medication changes, or patient condition. This education includes emphasis on thorough documentation. Nurse in-service was conducted on November 7th to include special instruction on disease management and teaching to patient, caregivers, and ALF staff (as it applies). RN's were instructed specifically on CHF & Diabetic patients including how to ensure that MD orders are being followed in the patients at home as well as those in ALF's. Nurses are responsible for coordinating with ALF staff to ensure MD orders are followed. If patient has a change in condition, then it is mandatory that the case manager coordinates with the ALF staff to ensure MD orders are being followed properly. It is also the nurse's responsibility to notify the MD of the change in condition in order to obtain pertinent orders as needed. The nurse is also responsible for the oversight of the ALF use of medications as ordered by MD. Any changes in medication	Kerri Harpole, RN BSN Administrator Teri Bruha, RN Director of Clinical Services Janice Fountain, PT Rehabilitation Director	Ongoing Weekly & Quarterly Audits	December 3rd, 2013

	must be updated on Legacy's MAR and if the patient's condition changes, the case manager must coordinate with the ALF Nurse to ensure that PRN medications are being used appropriately. The nurses were also instructed that they are also responsible for ensuring that weights on CHF patients are obtained and recorded as ordered. If the patient does not have a scale, then our RN must bring a scale from the office and obtain weights on their visits, then notify the MD of patient inability to obtain weights, and coordinate with family, caregiver, physician, MSW, etc. to find community resources to obtain scale. If the patient resides in an ALF, then the RN must inquire of the weights obtained by ALF and assess the patient condition. If there is a weight gain/loss beyond parameters set by MD, then we must notify MD of changes. If a patient has a diagnosis of Diabetes then the RN must verify with the patient if they are checking blood sugars and if they have a glucometer. If they are not checking blood sugars, then the RN must clarify with the physician if they want blood sugars checked and the frequency. If the physician doesn't want the patient to check blood sugars then the nurse must obtain an order stating as such. If they do want them checked, then the RN must inquire of the blood sugar ranges at each visit. If the sugars are outside of parameters, then the physician must be notified. If the patient does not own a glucometer, then the nurse must check the blood sugar at each visit and notify the MD so that a prescription can be received for the patient to obtain one. In addition, Legacy has purchased glucometers and scales that are available to all the nurses to use while in the patient home. Staff has been and will continue to be educated to be realistic and specific with their plan of care and supplemental goals and they must be measureable. Every clinician must review the Plan of Care at each visit to ensure that the agency has orders for all DME, oxygen, etc. and that the patient is currently using them. If not, then the clinician must find out why and notify the physician of the change. Also, if the patient adds oxygen, medications (including OTC), or DME, the clinician must obtain an order for the use of the product.			
G156 G159 N153	All clinicians have been educated at mandatory staff meetings regarding the requirement that they must have orders for every patient visit prior to the visit. It is acceptable to call and obtain verbal orders which then must be followed up with signed orders. It is not acceptable to make visits without a verbal or signed order.	Kerri Harpole, RN BSN Administrator Teri Bruha, RN Director of Clinical Services	Ongoing Weekly & Quarterly Audits	December 3rd, 2013

	Clinicians were also instructed to evaluate the entire patient not just a particular diagnosis. If we open a patient for wound care and they have an underlying co-morbidity, we have an obligation to oversee and instruct on disease management as well. All plans of care must have information regarding our plan for management co-morbidities such as CHF, Diabetes, nutritional deficiencies, COPD, etc. At the nurses meeting all RN's were provided with a teaching packet that they are to utilize to teach the patient/caregiver on each disease process. The nurses were also provided with portable file boxes to allow for availability of these teaching packets in their car. If a patient has a diagnosis of Diabetes then the RN must verify with the patient if they are checking blood sugars and if they have a glucometer. If they are not checking blood sugars, then the RN must clarify with the physician if they want blood sugars checked and the frequency. If the physician doesn't want the patient to check blood sugars then the nurse must obtain an order stating as such. If they do want them checked, then the RN must inquire of the blood sugar ranges at each visit. If the sugars are outside of parameters, then the physician must be notified. If the patient does not own a glucometer, then the nurse must check the blood sugar at each visit and notify the MD so that a prescription can be received for the patient to obtain one. Nurses were also instructed that they are also responsible for ensuring that weights on CHF patients are obtained and recorded as ordered. If the patient does not have a scale, then our RN must bring a scale from the office and obtain weights on their visits, then notify the MD of patient inability to obtain weights, and coordinate with family, caregiver, physician, MSW, etc. to find community resources to obtain scale. If the patient resides in an ALF, then the RN must inquire of the weights obtained by ALF and assess the patient condition. If there is a weight gain/loss beyond parameters set by MD, then we must notify MD of these changes. In addition, Legacy has purchased glucometers for all the nurses and scales are available for the nurses to use while in the patient home. Staff has been and will continue to be educated to be realistic and specific with their plan of care and supplemental goals and they must be measureable. To address nutrition, we are obtaining a contract with a dietician to utilize if we receive an order for a dietary consult. If a dietitian is not available at the time of the referral, then we must have an order for the nurse to do the dietary teaching or refer the patient to a different home health agency. If the nurse is to educate the patient on nutrition, then they are to utilize the teaching handouts that have specific guidelines for the disease process (i.e. CHF, DM I, or DM II).	Janice Fountain, PT Rehabilitation Director		

K[illegible] RN, BSN. Legacy Home Health Administrator 11/27/13

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

November 15, 2013

Kerri Harpole, Administrator
Legacy Home Health
680 S Progress Avenue, Suite 2A
Meridian, ID 83642

RE: Legacy Home Health, Provider #137106

Dear Ms. Harpole:

On **November 1, 2013**, a complaint survey was conducted at Legacy Home Health. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006223

Allegation #1: A nurse made inappropriate comments to patients.

Findings #1: An unannounced visit was made to the home health agency on 10/28/13-11/01/13. The visit included a full Medicare recertification survey and state licensure survey. Eight home visits were conducted to observe care. Patients, family, and staff were interviewed. Medical records for 17 patients were reviewed. Policies, meeting minutes, grievances, and quality documents were reviewed.

No evidence of disrespectful comments was found through interview or record review. All patients and families interviewed stated staff were compassionate and respectful. No grievances filed in 2013 alleged incidents of disrespectful speech. Staff who cared for the patient identified in the complaint were interviewed. No evidence of inappropriate behavior or speech was identified.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Patient information was shared with other providers without the patient's permission.

Findings #2: An unannounced visit was made to the home health agency on 10/28/13-11/01/13. The visit included a full Medicare recertification survey and state licensure survey. Eight home visits were conducted to observe care. Patients, family, and staff were interviewed. Medical records for 17 patients were reviewed. Policies, meeting minutes, grievances, and quality documents were reviewed.

All patient medical records contained a form titled "PATIENT CONSENT, ACKNOWLEDGEMENT & SERVICE AGREEMENT" signed and dated at the time of admission. The forms stated the agency could disclose protected health information with insurance companies and other health care providers involved in patients' care in order to coordinate care or "initiate treatment." All of the records contained signed consents with the above provision. No medical records indicated protected health information was disclosed inappropriately.

One medical record documented a 46 year old female who was admitted for home health care on 5/07/13 and was discharged on 9/16/13. She was admitted to manage extreme lymphedema in her legs.

The patient's lymphedema was managed by an occupational therapist with specialized training. According to staff, the occupational therapist went on a leave of absence the first part of September 2013. This left the agency without qualified staff to manage the patient's lymphedema. The record documented staff searched for another home health agency with qualified staff to care for the patient. A communication note, dated 9/13/13 at 5:03 PM, stated "Called and talked with patient about the change in available staff for lymphedema. Patient has asked to be transferred to another home health. Call made to MD to let them know that we would be unable to keep her on service at this time and that we would be transferring her to (specific home health agency). All records sent to (specific home health agency)..." A communication note, dated 9/17/13 at 12:27 PM, stated the patient was informed that another home health agency with specialized personnel had agreed to accept her as a patient. The note stated the patient "...was happy with this option and that she was looking forward to having (new agency) come out to see her..."

The Administrator and the Director of Clinical Services were interviewed on 10/31/13 beginning at 11:30 AM. They stated the therapist who cared for the above patient left on a leave of absence. They stated the patient gave permission for them to transfer her to another agency and said the patient gave permission to share her information with the new agency.

No instances were identified where patient information was inappropriately shared with unauthorized parties.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: A patient was inappropriately discharged from the agency.

Findings #3: An unannounced visit was made to the home health agency on 10/28/13-11/01/13. The visit included a full Medicare recertification survey and state licensure survey. Eight home visits were conducted to observe care. Patients, family, and staff were interviewed. Medical records for 17 patients were reviewed. Policies, meeting minutes, grievances, and quality documents were reviewed.

No cases were identified of patients who were discharged inappropriately.

One medical record documented a 46 year old female who was admitted for home health care 5/07/13 and was discharged on 9/16/13. She was admitted to manage extreme lymphedema in her legs.

The patient's lymphedema was managed by an occupational therapist with specialized training. According to staff, the occupational therapist went on a leave of absence the first part of September 2013. The agency did not have qualified staff to manage the lymphedema. The record documented staff informed the patient and searched for another home health agency with qualified staff to care for her. A communication note, dated 9/13/13 at 5:03 PM, stated "Patient has asked to be transferred to another home health. Call made to MD to let them know that we would be unable to keep her on service at this time and that we would be transferring her to (specific home health agency)." A communication note, dated 9/17/13 at 12:27 PM, stated the patient was informed that another home health agency with specialized personnel had agreed to accept her as a patient. The note stated the patient "...was happy with this option and that she was looking forward to having (new agency) come out to see her..."

A communication note by the Clinical Coordinator for the patient's county of residence, dated 9/17/13 at 12:27 PM, stated a nurse from the agency called the patient to let her know an agency nurse would accompany a physical therapist from the receiving agency on a joint visit. The purpose of the visit was to introduce the new agency to the patient and make her feel more comfortable. A communication note, dated 9/20/13 at 4:12 PM, stated the current agency nurse had completed the visit with the new agency's therapist on 9/18/13. The note stated the receiving agency had later phoned Legacy Home Health and stated they were sending a second therapist to evaluate the patient to determine if she was beyond the receiving agency's ability to care for her. A communication note by the administrator, dated 9/20/13 at 4:37 PM, stated she called the patient on the morning of 9/19/13 to inform her that the receiving agency had refused to admit the patient because she was beyond their level of care. The note stated the agency also could not care for the patient. The note stated the administrator recommended the patient go to an inpatient rehabilitation facility and offered to assist the patient with the admission. The patient refused assistance to find an inpatient facility to transfer to.

The Administrator and the Director of Clinical Services were interviewed on 10/31/13 beginning at 11:30 AM. They stated Legacy Home Health had to discharge the patient in order for the new agency to admit her. They stated the new agency then decided they were unable to provide care for the patient. They stated the patient was beyond the level of care for Legacy Home Health so they could not readmit her. They stated they attempted to assist the patient to find appropriate placement but she refused.

No instances were identified where patients were inappropriately discharged.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/pt