IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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BUREAU OF FACILITY STANDARDS
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December 3, 2013

Duke Vancampen, Administrator
Encompass Home Health & Hospice Of Idaho
6688 N. Central Expwy, Suite 1300
Dallas, TX 75206

RE: Encompass Home Health & Hospice Of Idaho, Provider #137100

Dear Mr. Vancampen:

This is to advise you of the findings of the Medicare/Licensure survey at Encompass Home Health & Hospice Of Idaho, which was concluded on November 18, 2013.

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

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

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

After you have completed your Plan of Correction, return the original to this office by **December 16, 2013**, and keep a copy for your records.

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

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/pmt
Enclosures

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137100	A. BUILDING _____ B. WING _____	11/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCOMPASS HOME HEALTH & HOSPICE OF IDAHO	512 N KINGS ROAD NAMPA, ID 83687

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G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your home health agency conducted from 11/12/13 through 11/18/13. The surveyors conducting the recertification were: Gary Guiles, RN, HFS, Team Leader Don Sylvester, RN, BSN, HFS Acronyms used in this report include: CPAP-Continous Positive Airway Pressure DME-Durable Medical Equipment mg/dl-Milligram Per Deciliter MSW-Masters Social Work PT-Physical Therapy POC-Plan Of Care RN-Registered Nurse SN-Skilled Nurse SOC-start of care	G 000	Per Administrator, the Plan of Correction for each deficiency is attached. S. Creswell 12/18/13	
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	RECEIVED DEC 16 2013 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ✓ TITLE RN Admin (X6) DATE 12-13-13

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 159	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, review of medical records, and staff interview, it was determined the agency failed to ensure the POC covered all pertinent diagnoses to provide care for 6 of 18 patients (#6, #7, #13, #14 #16, and #17) whose records were reviewed. This had the potential to interfere with continuity and completeness of patient care. Findings include: 1. Patient #17's medical record documented a 68 year old male whose SOC was 9/25/13. He was currently a patient as of 11/15/13. His diagnoses included aftercare for a fractured hip and chronic obstructive pulmonary disease. A SN "Visit Note Report," dated 9/25/13, but not timed, stated Patient #17 was receiving 5 liters of oxygen per minute continuously. A PT visit note, dated 10/01/13 at 10:02 AM, stated Patient #17 was receiving oxygen at 5 liters per minute. A SN visit note, dated 10/03/13 at 2:23 PM, stated Patient #17 was receiving oxygen at 5 liters per minute. A PT visit note, dated 10/08/13 at 2:47 PM, stated Patient #17 was receiving oxygen at 2 liters per minute. Patient #17's POC for the certification period 9/25/13 to 11/23/13, stated he was on oxygen precautions and directed the nurse to assess his use of oxygen. However, the POC did not specify a flow rate for the oxygen. Also, an order for oxygen use was not present in the medical record. The Nampa Branch Director was interviewed on 11/15/13 beginning at 4:05 PM. She confirmed Patient #17 used continuous oxygen but his POC	G 159		

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G 159	Continued From page 2 did not specify how much oxygen to administer. Patient #17's POC did not include an order for oxygen use or specify how much oxygen was to be administered. 2. Patient #16's medical record documented a 67 year old male whose SOC was 9/12/13. He was currently a patient as of 11/18/13. His diagnoses included a pressure ulcer, bilateral below the knee amputations, and diabetes. Patient #16's "Client Information Report," dated 9/26/13 at 9:50 PM, stated "PATIENT REPORTED TO CLINICIAN TODAY THAT HIS BROTHER HAS BEEN STEALING HIS OXYCODONE PILLS. HE REPORTED THAT HIS BROTHER STEALS 1-2 PILLS EACH TIME HE TAKES THEM." Patient #16's POC for the certification period 11/11/13 to 1/09/14, did not address the misappropriation of his Oxycodone. The Branch Director for the Pocatello branch was interviewed on 11/18/13 beginning at 10:55 AM. She stated Patient #16's brother had been asking him for Oxycodone and the patient had been giving them to the brother. She stated the RN Case Manager had discussed this with Patient #16. She stated a plan had not been developed to prevent the diversion of medication from Patient #16. She confirmed the POC for the certification period 11/11/13 to 1/09/14 did not address the diversion of Oxycodone. Patient #16's POC did not cover the misappropriation of Oxycodone.	G 159		

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G 159	Continued From page 3 3. Patient #6's medical record documented a 34 year old male whose SOC was 6/23/13. He was currently a patient as of 11/15/13. His primary diagnosis was paraplegia. Patient #6's POC for the certification period 10/21/13 to 12/19/13 included alcohol and catheter supplies. A visit was made to Patient #6's home with the Social Work Assistant on 11/13/13, beginning at 1:10 PM. Items observed for Patient #6's care included a wheelchair, shower chair, bridge, Hoyer lift, and a hospital bed. This adaptive equipment was not included in Patient #6's POC. Patient #6's POC did not cover the use of adaptive equipment. 4. Patient #14 was a 90 year old female admitted to the agency on 9/05/13, for diagnoses including aftercare surgery, muscle weakness, congestive heart failure, and coronary artery disease. Her medical record for the certification period of 11/04/13 to 1/02/14 was reviewed. The POC documented DME/supplies as alcohol, support braces and gloves. A SN "Visit Note Report", dated 11/01/13, stated DME available was a tub chair, elevated toilet seat, and grab bars. These items were not included on the POC. The Clinical Operations Consultant was interviewed on 11/13/13 beginning at 10:30 AM. She reviewed Patient #14's medical record and confirmed the DME/supplies on the POC were inaccurate. Patient #14's POC did not include all pertinent information.	G 159		

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G 159	Continued From page 4 5. Patient #7 was a 56 year old male admitted to the agency on 10/19/13, for diagnoses including essential hypertension, depressive disorder, and clostridium difficile. His medical record and POC, for the certification period of 10/19/13 to 12/17/13, was reviewed. The POC documented DME/supplies as briefs/bladder control pads. During a PT visit on 11/14/13, starting at 1:00 PM, a surveyor completed a review of DME with Patient #7. Patient #7 had a CPAP machine and a cane. The CPAP machine and cane were not listed as DME on the POC. The Clinical Operations Consultant was interviewed on 11/13/13 beginning at 10:30 AM. She reviewed Patient #7's medical record and confirmed the DME on the POC was inaccurate. Patient #7's POC did not list all DME. 6. Patient #13 was a 67 year old female admitted to the agency on 8/29/12, for diagnoses including paralysis agitans [Parkinson's Disease], chronic kidney disease stage II and noninfectious lymphedema [swelling of the arm or leg caused by a blockage in the lymphatic system]. Her medical record, including her POC, for the certification period of 10/23/13 to 12/21/13 was reviewed. The POC documented DME/supplies as alcohol, cane, walker, and gloves. During an observation of a SN visit on 11/22/13, beginning at 3:00 PM, a surveyor completed a	G 159		

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G 159	Continued From page 5 review of DME with Patient #13. Patient #13 had a toilet riser, grab bars, trapeze, reachers and sequential compression device. These items were not included on the POC as DME. The Nampa Branch Director was interviewed on 11/18/13 beginning at 8:45 AM. She reviewed Patient #13's medical record and confirmed the DME on the POC was inaccurate. Patient #13's POC did not list all DME.	G 159		
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 review of medical records and staff interview, it was determined the agency failed to ensure the RN initiated appropriate nursing procedures for 1 of 18 patients (#3) whose records were reviewed. This resulted in a lack of appropriate nursing assessment of a patient with low blood sugar levels. Findings include: 1. Patient #3 was a 69 year old female admitted to the agency on 9/12/2012, for diagnoses including diabetes mellitus, anxiety, osteoarthrosis, and depressive disorder. Her medical record and POC for the certification period of 9/12/12 through 11/10/12 were reviewed. Her POC included orders for blood sugar checks each SN visit. The POC documented skilled nurse orders as	G 175		

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G 175	Continued From page 6 follows: may administer four ounces of fruit juice or one tablespoon of sugar, for blood sugar analysis between 60-80 mg/dl, and recheck blood sugar in fifteen to twenty minutes if subsequent blood sugar is greater than 80 mg/dl, administer insulin." SN services provided were not consistent with this order. Examples include: -A SN "Visit Note Report", dated 9/17/12, documented Patient #3's blood sugar reading as 74 mg/dl. There was no re-evaluation of blood sugar level or assessment of signs and symptoms of hypoglycemia documented in Patient #3's medical record. -A SN "Visit Note Report", dated 9/21/12, documented Patient #3's blood sugar reading as 73 mg/dl. There was no re-evaluation of blood sugar level or assessment of signs and symptoms of hypoglycemia documented in Patient #3's medical record. -A SN "Visit Note Report", dated 10/08/12, documented Patient #3's blood sugar reading as 78 mg/dl. There was no re-evaluation of blood sugar level or assessment of signs and symptoms of hypoglycemia documented in Patient #3's medical record. During an interview on 11/12/13 at 3:15 PM, the Clinical Operations Consultant reviewed Patient #3's medical record. She confirmed Patient #3's blood sugar levels were not re-assessed. Appropriate nursing procedures were not provided in response to Patient #3's low blood sugar levels.	G 175		
G 195	484.34 MEDICAL SOCIAL SERVICES	G 195		

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G 195	Continued From page 7 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. This STANDARD is not met as evidenced by: Based on staff interviews and review of medical records and agency policies, 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 6 of 9 patients (#1, #2, #4, #5, #9, and #18) whose records were reviewed for social services. This resulted in a lack of assessment and care planning for patients receiving social services and a lack of supervision of Social Worker Assistant. Findings include: 1. Patient #1 was an 85 year old female admitted to the agency on 9/28/13, for diagnoses including gastroenteritis and colitis, hypothyroidism, senile dementia and vitamin D deficiency. Her medical record and POC for the certification period 9/28/13 through 11/26/13 was reviewed. Her 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		

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G 195	Continued From page 8 An "MSW Visit Note", dated 10/01/13, stated the Social Work Assistant completed an initial evaluation. There was no documentation to show the Social Worker had been involved in Patient #1's care. The Nampa Branch Social Worker was interviewed on 11/18/13 beginning at 9:12 AM. She stated the Social Work Assistant provided services directly and she supervised the assistant. She stated she reviewed all evaluations and progress notes completed by the Social Work Assistant on a weekly basis. She reviewed Patient #1's medical record and confirmed there was no documentation of oversight by the Social Worker. She also checked and stated there was no documentation of oversight in administrative records. Medical Social Services were not provided by or under the supervision of a qualified Social Worker. 2. Patient #5 was an 88 year old female admitted to the agency on 10/29/13, for diagnoses including cerebral vascular disease, aphasia and dysphagia. Her medical record and POC for the certification period 10/29/13 through 12/27/13 was reviewed. Her 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 11/07/13, stated the Social Work Assistant completed an initial evaluation. There was no documentation to show	G 195		

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G 195	Continued From page 9 the Social Worker had been involved in Patient #5's care. The Nampa Branch Social Worker was interviewed on 11/18/13 beginning at 9:12 AM. She stated the Social Work Assistant provided services directly and she supervised the assistant. She stated she reviewed all evaluations and progress notes by the Social Work Assistant on a weekly basis. She reviewed Patient #5's medical record and confirmed there was no documentation of oversight by the Social Worker. She also checked and stated there was no documentation of oversight in administrative records. Medical Social Services were not provided by or under the supervision of a qualified Social Worker. 3. Patient #9 was an 97 year old female admitted to the agency on 10/10/13, for diagnoses including muscle weakness, atrial fibrillation, edema and hereditary peripheral neuropathy. Her medical record and POC for the certification period 10/10/13 through 12/08/13 was reviewed. Her 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 10/17/13, stated the Social Work Assistant completed an initial evaluation. There was no documentation to show the Social Worker had been involved in Patient #9's care.	G 195		

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G 195	Continued From page 10 The Nampa Branch Social Worker was interviewed on 11/18/13 beginning at 9:12 AM. She stated the Social Work Assistant provided services directly and she supervised the assistant. She stated she reviewed all evaluations and progress notes by the Social Work Assistant on a weekly basis. She reviewed Patient #9's medical record and confirmed there was no documentation of oversight by the Social Worker. She also checked and stated there was no documentation of oversight in administrative records. Medical Social Services were not provided by or under the supervision of a qualified Social Worker. 4. Patient #2's medical record documented an evaluation by the Social Work Assistant on 11/06/13 at 3:30 PM. The evaluation stated Patient #2 was seen for depression. The evaluation stated there was no need for further social work visits. There was no documentation to show the Social Worker had been involved in Patient #2's care. The Nampa Social Worker was interviewed on 11/18/13 beginning at 9:12 AM. She stated the Social Work Assistant provided services directly and she supervised the assistant. She stated she reviewed all evaluations and progress notes by the Social Work Assistant on a weekly basis. She stated she was responsible for supervision of the Social Work Assistant. She reviewed Patient # 2's medical record and confirmed there was no documentation of oversight by the Social Worker. She also checked and stated there was no documentation of oversight in administrative	G 195		

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G 195	Continued From page 11 records. Medical Social Services were not provided under the supervision of a qualified Social Worker. 5. Patient #4's medical record documented a 72 year old female whose SOC was 8/20/13. She was currently a patient as of 11/13/13. Her diagnoses included recent surgery for a ventral hernia and diabetes. Patient #4's medical record documented an evaluation by the Social Work Assistant on 8/22/13 at an unknown time. A summary of the evaluation and a plan for social services were not documented. However, a "PHYSICIAN VERBAL ORDER." dated 8/22/13 at 11:45 AM, stated no additional social work visits were required. The Nampa Social Worker was interviewed on 11/18/13 beginning at 9:12 AM. She reviewed Patient # 4's medical record and confirmed there was no documentation of oversight by the Social Worker. Medical Social Services were not provided under the supervision of a qualified Social Worker. 6. .Patient #18's medical record documented a 78 year old female whose SOC was 9/28/13. She was currently a patient as of 11/18/13. Her diagnoses included rheumatoid arthritis and a history of stroke. Patient #18's medical record documented an evaluation by the Social Work Assistant on 9/30/13 at 6:42 PM. A second visit by the Social Work Assistant was documented on 10/08/13 at 8:02 PM.	G 195		

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G 195	Continued From page 12 The Nampa Branch Manager was interviewed on 11/18/13 beginning at 1:40 PM. She reviewed Patient # 18's medical record and confirmed there was no documentation of oversight by the Social Worker. Medical Social Services were not provided under the supervision of a qualified Social Worker. 7. The Nampa Social Worker was interviewed on 11/18/13 beginning at 9:12 AM. A policy for oversight by the Social Worker was requested. She stated the agency had not developed a policy that specified what type of oversight by the Social Worker was required or how this was to be documented. The agency had not developed a policy for Social Worker oversight.	G 195		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001230	A. BUILDING: _____ B. WING _____	11/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCOMPASS HOME HEALTH & HOSPICE OF II	512 N KINGS ROAD NAMPA, ID 83687

(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 licensure survey of your home health agency on 11/12/13 through 11/18/13. The surveyors conducting the survey were: Gary Guiles, RN, HFS - Team Leader Don Sylvester, BSN, RN, HFS	N 000	Per Administrater, the Plan of Correction for each citation is attached. S. Creswell 12/18/13	
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 G175 as it relates to the failure of the agency to ensure the RN initiated appropriate nursing procedures.	N 092		
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:	N 155		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001230	A. BUILDING: _____ B. WING _____	11/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCOMPASS HOME HEALTH & HOSPICE OF II	512 N KINGS ROAD NAMPA, ID 83687

(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 155	Continued From page 1 Refer to G159 as it relates to the failure of the agency to ensure patients' POCs included all pertinent services and equipment.	N 155		

MEDICARE/LICENSURE SURVEY PLAN OF CORRECTION
ENCOMPASS HOME HEALTH
PREPARED BY: CARRIE BIRCH, RN, BRANCH DIRECTOR
(RESULTS RECEIVED FROM BUREAU OF FACILITY STANDARDS ON: DECEMBER 6, 2013)

G 159 484.18 (a) PLAN OF CARE
N 155 03.07030
"The plan of care developed in consultation with the agency staff covers all pertinent diagnoses,...equipment required...medications and treatments, any safety measures to protect against injury,...and any other pertinent items."

DEFICIENCY:
Plan of care did not cover all pertinent diagnoses, medication use/misuse/misappropriation, use of adaptive equipment, DME's and other pertinent information which had the potential to interfere with continuity and completeness of patient care.

PLAN OF ACTION:
- Orders for oxygen will be obtained by physician order to include correct route, frequency of use, and flow rate.
- "Oxygen equipment/supplies" will be listed in the patient's record.
  -This information will then be forwarded to the HH POC/485 under "DME/Supplies" (Locator box #14)
- Specifics of oxygen use including route, frequency, flow rate will be documented on Medication Profile of patient's record.
  -This information will then be forwarded to the HH POC/485 in (Locator box #10)
- A complete list of all DME and adaptive equipment will be obtained at initial home health visit and, as needed, thereafter and will be listed in the patient's record.
  -This information will then be forwarded to the HH POC/485 in (Locator box #14).
- All medications prescribed by patient's physician will be listed on the Medication Profile in the patient's record.
  -This information will then be forwarded to the HH POC/485.
- Any misuse, non-compliance or misappropriation of patient's medications will be documented on an Occurrence Report and the patient's physician will be contacted in writing of the agency's plan to address medication issues.

GOAL:
- The patient's record will contain a complete and accurate list of all medications, adaptive equipment and DME obtained by the admitting clinician and will be available in the patient's record for subsequent clinicians to review/add/delete, as appropriate, at future visits.
- This will ensure that the HH POC/485 that is sent to the physician for signature is also complete and accurate.
- The patient will have the appropriate medication and equipment in the home to remain safe and adverse symptoms controlled with medication.

DATE:
- Staff will be in-serviced on December 11, 2013- Nampa, Twin Falls
- Staff will be in-serviced on December 12, 2013- Pocatello
  (In-service attendance record attached)

MONTIOR/TRACK:

- Compliance will be immediate and ongoing
- 10% of records with patients utilizing DME/adaptive equipment and/or medication 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 one year.
- Compliance will be monitored by Regional Packet Review/Quality Improvement and/or Clinical Field Staff Supervisor and Branch Director.

G175 484.30(a) DUTIES OF THE REGISTERED NURSE
N 092 03.07024.01 SK.NSG.SERV.
"The registered nurse initiates appropriate preventative and rehabilitative nursing procedures".

DEFICIENCIES:
The agency failed to ensure the RN initiated appropriate nursing procedures which resulted in a lack of appropriate nursing assessment of a patient with low blood sugar levels.

PLAN OF ACTION:
- Diabetic patients for whom insulin is administered by agency clinicians, will have physician ordered parameters for blood glucose levels, treatment of blood sugars outside of parameters and orders of when the physician wishes to be notified, documented in patient's record.
  -This information will then be forwarded to the HH POC/485

GOAL:
- The patient's record and the HH POC/485 will contain specific orders of when and how to treat hypo/hyperglycemia and when the physician wishes to be notified of blood glucose levels outside of the parameters.
- This will ensure consistent treatment of the patient's symptoms by all clinicians which should, in turn, result in better management of patient's disease process.

DATE:
- Staff will be in-serviced on December 11, 2013- Nampa, Twin Falls
- Staff will be in-serviced on December 12, 2013- Pocatello
  (In-service attendance record attached)

MONITOR/TRACK
- Compliance will be immediate and ongoing
- 10% of records with patients receiving insulin injections by agency clinicians, 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 Packet Review/Quality Improvement and/or Clinical Field Staff Supervisor and Branch Director

G195 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..."

DEFICIENCIES:
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. This resulted in a lack of assessment and care planning for patients receiving social services and a lack of supervision of social worker assistant.

PLAN OF ACTION:
- 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
- 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.

- 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 by the Branch Director, as well as, electronically archived.

GOAL:

- The patient will receive social work services as ordered by the physician.
- A process will be implemented to ensure that medical social services are provided by or under the supervision of a qualified social worker as outlined in the current "Professional Personnel Competency and Supervision" policy (*Policy and Procedure Manual: Personnel, 1.0-Professinal Personnel Competency and Supervision*). (attached)
- The aforementioned process will ensure that the patient's psychosocial needs are met

DATE:

- Staff will be in-serviced on December 11, 2013- Nampa, Twin Falls
- Staff will be in-serviced on December 12, 2013- Pocatello
  (In-service attendance record attached)

MONITOR/TRACK:

- 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