



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 9901**

January 7, 2014

Sharon Anitok, Administrator  
Multicare Home Health Services, Inc  
P.O. Box 355  
Meridian, ID 83680

RE: Multicare Home Health Services, Inc, Provider #137093

Dear Ms. Anitok:

Based on the survey completed at Multicare Home Health Services, Inc, on December 20, 2013, by our staff, we have determined Multicare Home Health Services, Inc is out of compliance with the Medicare Home Health Agency (HHA) **Conditions of Participation of Organization, Services & Administration (42 CFR 484.14), Group of Professional Personnel (42 CFR 484.16), Acceptance of Patients, POC, Med Super (42 CFR 484.18), Clinical Records (42 CFR 484.48) and Evaluation of the Agency's Program (42 CFR 484.52)**. 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 these conditions to be unmet, substantially limit the capacity of Multicare Home Health Services, Inc, 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;

Sharon Anitok, Administrator

January 7, 2014

Page 2 of 2

- 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 February 3, 2014. 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 January 22, 2014.**

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **January 20, 2014.**

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 correction immediately.

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

Sincerely,



SYLVIA CRESWELL

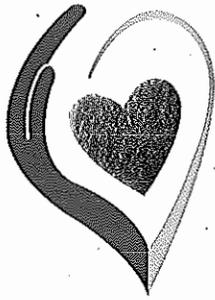
Co-Supervisor

Non-Long Term Care

SC/pmt

Enclosures

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



# MULTICARE

Home Health

"Caring  
From  
The Heart"

January 22, 2014

RECEIVED

JAN 23 2014

FACILITY STANDARDS

Sylvia Creswell, Co-Supervisor, Non-Long Term Care  
Department of Health & Welfare  
Bureau of Facility Standards  
3232 Elder Street  
PO Box 83720  
Boise, ID 83720

Dear Ms. Creswell,

Enclosed, please find MultiCare Home Health's added information to the Plan of Correction (POC).

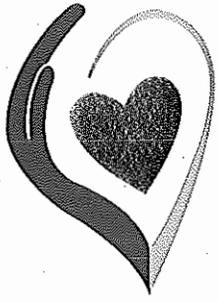
We have addressed the items outlined and added completion dates. The POC pages impacted are being submitted and noted as revised.

Thanks you for answering our questions, and please let us know if there is any other items that need addressed.

Best Regards,

Sharon Anitok  
Administrator

Cc: Sharon Anitok  
Cc: Lori Page  
Cc: Robin Wallis



# MULTICARE

Home Health

"Caring  
From  
The Heart"  
January 17, 2014

Sylvia Creswell, Co-Supervisor, Non-Long Term Care  
Department of Health & Welfare  
Bureau of Facility Standards  
3232 Elder Street  
PO Box 83720  
Boise, ID 83720

RECEIVED

JAN 21 2014

FACILITY STANDARDS

Dear Ms. Creswell,

Enclosed, please find MultiCare Home Health's response to our December 20, 2013 survey conducted by Susan Costa, RN, Team Leader, Gary Guiles, RN, HFS, and Libby Doane, RN, BSN, HFS.

We have addressed each deficiency and handled according to the specifications outlined in the cover letter and summary statement of deficiencies.

We appreciate the feedback that will allow MultiCare Home Health to correct, improve and create new processes to promote quality home health care services.

Please let us know if you there are any questions.

Best Regards,

Lori Page, RN  
Director of Clinical Services

Sharon Anitok  
Administrator

Cc: Sharon Anitok

Cc: Lori Page

Cc: Robin Wallis

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

PRINTED: 01/06/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/20/2013
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NAME OF PROVIDER OR SUPPLIER  MULTICARE HOME HEALTH SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 324 SOUTH MERIDIAN RD, SUITE 10 MERIDIAN, ID 83642
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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G 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification survey of your home health agency conducted on 12/16/13 through 12/20/13.</p> <p>The surveyors conducting the recertification were:</p> <p>Susan Costa, RN, HFS - Team Leader Gary Guiles, RN, HFS Libby Doane, RN, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>ADA - American Diabetes Association ADL - Activity of Daily Living A-Fib - Atrial Fibrillation ALS - Amyotrophic Lateral Sclerosis, a disease of the central nervous system BID - Twice a Day BG - Blood Glucose BM - Bowel Movement BP - Blood Pressure CAD - Coronary Artery Disease CCU - Critical Care Unit CHF - Congestive Heart Failure COPD - Chronic Obstructive Pulmonary Disease cm - centimeters CM - Case Manager, an RN CVA - Cerebrovascular Accident dc - discharge DCS - Director of Clinical Services DM II - Type 2 Diabetes DME - Durable Medical Equipment E-Stim - Electrical Stimulation ER - Emergency Room HHA - Home Health Aide</p>	G 000	<p style="text-align: center;"><b>RECEIVED</b> JAN 21 2014 FACILITY STANDARDS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon Anitol TITLE: Administrator (X6) DATE: 17-Jan-2014

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

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G 000	Continued From page 1 HTN - Hypertension LPM - Liters Per Minute LPN - Licensed Practical Nurse mg - milligram MOM - Milk of Magnesia MSW - Masters of Social Work NC - Nasal Cannula O2 - Oxygen OT - Occupational Therapy PAC - Professional Advisory Committee, the title of the agency's group of professional personnel PCP - Primary Care Physician POC - Plan of Care PRN/prn - as needed psych - psychological pt - patient PT - Physical Therapy PTA - Physical Therapy Aide RN - Registered Nurse s/sx - signs and symptoms SN - Skilled Nursing ST - Speech Therapy w/c - wheelchair	G 000		
G 122	484.14 ORGANIZATION, SERVICES & ADMINISTRATION  This CONDITION is not met as evidenced by: Based on staff and patient interview, observation, review of clinical records, agency policies, and administrative documents, it was determined the Governing Body failed to provide direction and oversight to the agency. This resulted in a lack of support and guidance to agency personnel. Findings include:	G 122	G 122  Refer to G 130, G 132, G 141, G 144,  G 156, G 235, G 242  Governing Body meets semi-annually. Next official meeting scheduled 2/27/14. Governing Body is providing ongoing oversight for POC, Program Evaluation and Policy review. Four of six Governing Body members are PAC members. PAC met, reviewed POC,	

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JAN 23 2014

FACILITY STANDARDS

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G 122	<p>Continued From page 2</p> <ol style="list-style-type: none"> <li>1. Refer to G130 as it relates to the Governing Body's failure to arrange for professional advice.</li> <li>2. Refer to G132 it relates to the Governing Body's failure to oversee the management of the agency.</li> <li>3. Refer to G141 as it relates to the Governing Body's failure to ensure personnel practices were supported by written personnel policies.</li> <li>4. Refer to G143 as it relates to the Governing Body's failure to ensure agency personnel coordinated services.</li> <li>5. Refer to G144 it relates to the Governing Body's failure to ensure coordination of care efforts by agency personnel were documented.</li> <li>6. Refer to G151 Condition of Participation: Group of Professional Personnel not met and related standard level deficiencies as they relate to the Governing Body's failure to ensure the group of professional personnel carried out its duties.</li> <li>7. Refer to G156 Condition of Participation: Acceptance of Patients, Plan of Care, Medical Supervision not met and related standard level deficiencies as they relate to the Governing Body's failure to ensure POCs were developed, followed, and updated.</li> <li>8. Refer to G235 Condition of Participation: Clinical Records not met and related standard level deficiencies as they relate to the Governing Body's failure to ensure clinical records were maintained in accordance with accepted</li> </ol>	G 122	<p>Program Evaluation and Policy on 1/16/14. A single Policy &amp; Procedure is being utilized. Five of six Governing Body members have reviewed and approved PAC minutes, policies, Program Evaluation prior to Governing Body meeting scheduled on 2/27/14. There is no anticipation of major content changes to policies at Governing Board meeting.</p> <p>Addendum #9</p> <p>Completion date 1/21/14</p>	
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G 122	Continued From page 3 professional standards.	G 122			
G 130	<p>9. Refer to G242 Condition of Participation: Evaluation of the Agency's Program not met and related standard level deficiencies as they relate to the Governing Body's failure to ensure the agency's program was evaluated.</p> <p>The cumulative effect of these systemic failures seriously impeded the ability of the agency to provide services of sufficient scope and quality.</p> <p>484.14(b) GOVERNING BODY</p> <p>The governing body arranges for professional advice as required under §484.16.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of meeting minutes, it was determined the agency's Governing Body failed to arrange for professional advice. This resulted in a lack of oversight and direction to the agency. Findings include:</p> <p>Two sets of meeting minutes for the year 2013 were provided to surveyors. Both were hand written over an "AGENDA" titled "Semi Annual Meeting." The minutes, dated 7/11/13, and 12/03/13, did not document any PAC activities.</p> <p>The Administrator was interviewed on 12/19/13 beginning at 3:00 PM. She stated the above minutes were the official PAC minutes for the agency for the prior year. She stated no other documentation of the PAC's activities was available. She confirmed no documentation was present to show the PAC had established or reviewed agency policies. She confirmed no</p>	G 130	G 130	<p>The PAC has been realigned and will meet at least semi-annually. The PAC meetings to follow a clear and concise Agenda, including review of the Policy and Procedure updates. The PAC will establish and review agency policies, present changes and/or updates to Governing Body for approval, and then provide advice and direction to the agency staff during staffing meetings bi-monthly. The Administrator will be responsible for scheduling meetings, preparing agenda, and clearly documenting context of meeting. The Director of Clinical Services to be responsible for presenting policy updates to the PAC. MultiCare conducted PAC meeting on 1/16/14.</p>	

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G 130	Continued From page 4 documentation was present to show the PAC provided advice or direction to the agency.	G 130		
G 132	The Governing Body did not arrange for professional advice. 484.14(b) GOVERNING BODY  The governing body oversees the management and fiscal affairs of the agency.  This STANDARD is not met as evidenced by: Based on staff interview and review of meeting minutes, it was determined the agency's Governing Body failed to ensure it provided oversight of the management of the agency. This resulted in a lack of leadership and direction to staff. Findings include:  1. Two sets of meeting minutes for the year 2013 were provided to surveyors. Both were hand written over an "AGENDA" titled "Semi Annual Meeting." The minutes, dated 7/11/13, stated "Review [with] Carolyn's group Bob. Type up procedure for census. Approx. 10 days out currently (reg 7 day or - 2%). Place another ad for [weekend]. Eval's [DCS name, unknown person's name] Case mgr. Gov website [Assistant Administrator's name]. Policy & Proc [2 names]."  The meeting minutes, dated 12/03/13, were also incomplete. They stated "Yearly review completed. P&P ongoing updates." Under the heading "Current Census" was written 51-1 @ recurring. Current @ +2012 [with] Nov & Dec Pndg."	G 132	G 132  Governing Body to provide ongoing oversight of agency programs, meet at least semi-annually, and follow a clear and concise agenda. Minutes from PAC meetings (see G 130) to be reviewed and approved or changes submitted back to the PAC. The Governing Body to clearly document the policies that have been reviewed, revised, approved. No major content changes are anticipated to policies to be reviewed at next Governing Body meeting scheduled for 2/27/14 in which final approval will occur. The Governing Body, after review, will adopt as official policy. The Administrator will be responsible for scheduling meetings, and assure that all activities of meetings are clearly documented for submission to Governing Body. The Director of Clinical Services to be responsible for implementation of policies, and to	

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G 132	Continued From page 5 Neither set of minutes specifically documented agency issues or actions taken by the board.  The Administrator was interviewed on 12/19/13 beginning at 3:00 PM. She stated the above minutes were the official combined Governing Body meeting minutes and PAC minutes for the agency for the prior year. She stated no other documentation of the Governing Body's activities was available.  The governing body failed to document its activities.  2. Two separate comprehensive policy manuals were present at the agency. Neither were dated. They contained similar but different policies.  The Administrator was interviewed on 12/19/13 beginning at 1:15 PM. She stated the Governing Body felt the agency's policies and procedures were outdated. She stated the agency purchased new policies in September 2012. She stated staff had slowly been revising policies since then. She stated she could not tell which policies had been revised and which were in process. She stated there was no documentation clarifying which, if any, policies had been reviewed, revised, and approved by the Governing Body.  The governing body failed to adopt an official set of policies.	G 132	include in-service of staff to ensure staff is following policies and procedures. PAC met 1/16/14 and reviewed POC, Program Evaluation and Policies. Policies to be in-serviced at Home Health Staff meeting 1/21/14. Four of six Governing Body members also serve on PAC. Five of six Board Members reviewed and approved POC, Program Evaluation and Policies prior to in-service of staff 1/21/14.  Completion date 1/21/14		
G 141	484.14(e) PERSONNEL POLICIES  Personnel practices and patient care are supported by appropriate, written personnel policies.	G 141			

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G 141	<p>Continued From page 6</p> <p>Personnel records include qualifications and licensure that are kept current.</p> <p>This STANDARD is not met as evidenced by: Based on staff and patient interview, observation, review of medical records and personnel policies, it was determined the agency failed to develop written policies to direct staff on acceptable use of personal and business cell phones for transfer of patient information and photos. This directly impacted 1 of 1 patient (#7) whose wound care was observed during a home visit. This resulted in personal health information being transferred through non secure devices and the potential for unauthorized access to protected health information. Findings include:</p> <p>The following example illustrates the practice of agency staff related to taking photos of patient wounds and sending via cell phone messaging:</p> <p>On 12/18/13 at 7:30 AM, a visit to Patient #7's home was conducted to observe care provided by the HHA. She demonstrated how she would take a picture of Patient #7's wound and send the photo to the CM on her phone. She stated she would send the photo via her personal cellular phone, by means of messaging, to the CM. The photo was accompanied by the name of Patient #7, the date, and the fact that it was a photo of his wound.</p> <p>The CM was interviewed on 12/19/13 at 10:00 AM. She stated she had instructed the HHA to send photos of Patient #7's wound. She stated she was not aware of an agency policy that provided direction of how to share patient information between staff.</p>	G 141	<p>including the protection of the Patient's confidentiality. This policy was updated and reviewed by the PAC on 1/16/14, and will be forwarded to the governing body for final approval and adoption on 2/27/14. No major content changes to the Technology Policy are anticipated by the Governing Board. Four of six Governing Board members are on the PAC. Five of six Governing Board members reviewed prior to in-service of Home Health staff on 1/21/14. The Assistant Administrator is responsible for updating this policy. The Director of Clinical Services is responsible for presenting and in-service of Staff regarding the use of technology in the Patient's Home immediately and will have staff sign a memorandum of understanding to be completed on 1/21/14</p> <p>See Addendum #4 and #5</p> <p>Completion date 1/21/14</p>	
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G 141	Continued From page 7  During an interview on 12/19/13 beginning at 2:00 PM, the DCS was interviewed. She stated she was not aware the staff was transmitting photos of patients by cell phone. She stated the nursing staff had business cell phones and could take pictures of wounds in the patient's home then return to the office to print the photos for the patient record. She stated the staff was instructed to then delete the photos from their phones. The DCS confirmed there was no policy to direct the staff related to sharing of patient information using cellular phones.	G 141			
G 143	The agency failed to have a clear policy to direct staff on protecting patient confidentiality and the photographing of patients with personal and business cell phones.  484.14(g) COORDINATION OF PATIENT SERVICES  All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.  This STANDARD is not met as evidenced by: Based on staff interview, and review of medical records and agency policies, it was determined the agency failed to ensure care coordination between disciplines was documented for 4 of 12 patients (#2, #9, #13, and #14) who received services from more than one discipline and whose records were reviewed. This interfered with quality and continuity of patient care. Findings include:	G 143	G 143  The PAC will update our policy on Coordination of Patient Services to include effective coordination of Patient care Services through regular communication by the team of providers, and providing care within their scope of practice. The Director of Clinical Services will designate the Case Manager to coordinate the services provided to each Patient they are assigned too. The case manager will either be an RN or PT. This policy will be reviewed and updated at PAC		

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G 143	<p>Continued From page 8</p> <p>During an interview on 12/16/13 beginning at 9:00 AM, the DCS stated coordination among staff was documented in visit notes and "Care Coordination Notes," which included the individual with whom the communication was made. Coordination of patient care was not noted as follows:</p> <p>1. Patient #2's medical record documented an 56 year old female admitted to the agency on 7/10/13, with diagnoses including non healing surgical wound, HTN, and DM II. Her medical record, including her POC for the certification period of 7/10/13 through 9/07/13, was reviewed.</p> <p>An LPN documented a visit to Patient #2 on 7/29/13 from 5:30 PM to 7:00 PM. She documented Patient #2 was constipated and stated she had no bowel movement for 5 days. The LPN noted she then performed digital stimulation with no results. In addition, the LPN stated she instructed Patient #2 to take MOM and increase her activity. The nursing visit note for 7/29/13 also stated that, after the LPN left, Patient #2 had called her to say she had thrown up. The LPN documented she advised Patient #2 to go to the ER, and the patient did not want to go. The LPN wrote in her note "I told her to take more MOM before bed and if she had more throwing up to go to ER." The medication MOM was not on Patient #2's POC. There was no evidence of communication with the physician or CM regarding Patient #2's vomiting, constipation, or addition of medication.</p> <p>Patient #2's medical record was reviewed. Nursing notes documented Patient #2 had BM's each of the four days prior to the LPN's visit; 7/24/13, 7/25/13, 7/26/13, and 7/28/13.</p>	G 143	<p>meeting on 1/16/14. The Director of Clinical Services has already spent time with individual members of team, and verbally in-service regarding coordination of care; scope of practice, appropriate documentation i.e.: medications/treatments/use of communication note, and communication to PCP and other disciplines involved in the Patient's Plan of Care. The responsibility of updating this policy is the PAC, and approval of updated policy is the governing body. The Director of Clinical Services is responsible for implementation and orientation of staff. Date of completion is 1/21/14.</p> <p>See Addendum #6 and #7</p>		

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G 143	<p>Continued From page 9</p> <p>During an interview on 12/18/13 beginning at 3:00 PM, the LPN reviewed Patient #2's record and confirmed the nursing notes documented Patient #2 had BM's on 7/24/13, 7/25/13, 7/26/13, and 7/28/13. She stated the patient told her she had no bowel movement for 5 days so she performed the digital stimulation before reviewing Patient #2's record. The LPN stated she would perform digital disimpactions without a physicians' order. In addition, the LPN stated she instructed the use of MOM as it was an "over the counter" medication. The LPN stated she had not contacted the CM or the physician regarding Patient #2's constipation, vomiting, or the recommendation for her to go to the ER.</p> <p>Care was not coordinated regarding Patient #2's condition and medications.</p> <p>2. Patient #13's medical record documented a 76 year old male admitted to the agency on 10/28/13 with diagnoses including shoulder dislocation after a fall, dysmetabolic syndrome, and HTN. His medical record for the certification period of 10/28/13 through 12/26/13 was reviewed. Care was not coordinated as follows:</p> <p>a. The POC, signed by the physician but not dated, documented MSW visits were to be made twice a month for one month to assist Patient #13 with accessing resources to allow him to remain safely in his home.</p> <p>An MSW visit was made to Patient #13's home on 11/06/13. The MSW documented Patient #13 needed assistance with housekeeping and shopping, and assistance with applying for Medicaid, food stamps, emergency assistance</p>	G 143		

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G 143	<p>Continued From page 10</p> <p>and energy assistance. The MSW documented she assisted Patient #13 in completing an application for Medicaid. There was no documentation to indicate assistance with the other needs identified.</p> <p>There were no further MSW visits documented in the medical record at the time of the survey on 12/18/13. There was no documentation by the MSW indicting the status of Patient #13's Medicaid application or any other resources that may be available to him. There was no documentation to indicate the physician had been notified of the MSW's inability to provide 2 visits per month in accordance with the POC.</p> <p>The RN case manager reviewed the record and was interviewed on 12/19/13 at 8:10 AM. She confirmed the MSW had not made 2 visits per month in accordance with the POC. She confirmed there was no documentation from the MSW indicating the status of Patient #13's Medicaid application. She stated Patient #13 had been denied Medicaid. She also stated the MSW "really couldn't do anything for him because he makes too much money" and therefore had not continued to see Patient #13.</p> <p>The MSW did not coordinate with other disciplines providing care for Patient #13.</p> <p>b. A "COMMUNICATION NOTE," documented by the Occupational Therapist on 11/01/13, stated the Occupational Therapist had called Patient #13 to schedule his OT evaluation, but Patient #13 told her he had been admitted to the hospital earlier in the day and might go home the next day. The Occupational Therapist documented Patient #13 was unsure why he had been</p>	G 143			

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G 143	<p>Continued From page 11 admitted.</p> <p>A "PATIENT MISSED VISIT" note, documented by the Occupational Therapist on 11/02/13, stated Patient #13 had been admitted to the hospital on 11/01/13 for blood pressure issues but thought he would be home that night.</p> <p>A "COMMUNICATION NOTE," documented by the Occupational Therapist on 11/03/13, stated the Occupational Therapist spoke with Patient #13 on 11/02/13 and he stated he was still at the hospital but thought he would be discharged in the afternoon (on 11/02/13). She documented one of the PTAs had called her to say Patient #13 had been discharged but it was unclear how long he had been in the hospital.</p> <p>An RN visit note, dated 11/04/13, the CM documented "...apparently in the hospital over the weekend." There was no documentation to indicate how long he was in the hospital or for what reason.</p> <p>The CM reviewed the record and was interviewed on 12/19/13 at 8:10 AM. She stated Patient #13 had gone to the ER because of his HTN. She stated he had not been admitted. She confirmed there was no documentation to explain why Patient #13 had gone to the ER, nor was there documentation to indicate Patient #13's physician had been notified he had gone to the ER. She stated this information should have been documented in the "COMMUNICATION NOTE" to ensure all staff caring for Patient #13 were aware of his ER visit.</p> <p>c. An Occupational Therapist visit note, dated 11/06/13, documented Patient #13 had just</p>	G 143		

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G 143	<p>Continued From page 12</p> <p>picked up new prescriptions and had questions about possible interactions between the new medications. The Occupational Therapist documented she told Patient #13 the medications had been checked for interactions at the pharmacy already. She stated Patient #13 also requested she review discharge instructions from the hospital. The Occupational Therapist documented that it "...seemed that pt was trying to find things to be leary of." There was no documentation to indicate Patient #13's medication concerns had been communicated to the CM or the physician.</p> <p>The CM reviewed the record and was interviewed on 12/19/13 at 8:10 AM. She stated she was unaware Patient #13 had questions related to interactions of his medications, this had not been communicated to her by the Occupational Therapist.</p> <p>Care of Patient #13 was not coordinated among all disciplines.</p> <p>3. Patient #9's medical record documented a 75 year old female admitted to the agency on 4/05/13 with diagnoses including chronic bronchitis, CHF, CAD, and HTN. Her medical record for the certification period of 4/05/13 through 6/03/13 was reviewed.</p> <p>A "PHYSICAL THERAPY EVALUATION," documented by the Physical Therapist on 4/19/13, stated that Patient #9 had fallen during the evaluation visit. The OT note stated Patient #9 "was standing in living room demonstrating to me how she can't stand or walk without her walker and she started to teeter and fell onto her [left] side and was uninjured. She states the last</p>	G 143			

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G 143	<p>Continued From page 13</p> <p>time she fell was one year ago." There was no documentation the CM had been notified of the fall.</p> <p>The DCS reviewed the record and was interviewed on 12/18/13 at 1:15 PM. She stated it was the agency's practice to notify all disciplines caring for the patient of falls. She stated this would be accomplished in a communication note. The DCS confirmed there was no documentation the CM had been notified of Patient #9's fall.</p> <p>Patient #9's CM and physician were not notified of her fall.</p> <p>4. Patient #14's medical record documented a 65 year old female who was admitted to home health care on 5/06/13 and transferred to hospice care on 10/30/13. Her diagnoses included motor neuron disease (a progressive neurological disorder), and COPD.</p> <p>Patient #14's "DOCTORS ORDERS," dated 10/16/13 at 2:06 PM, stated "Patient was hospitalized from 9/30/13 to 10/02/13, however we were not informed of her discharge and did not receive documentation from [discharge] until today...Orders: Resume Home Health Services for SN and ST as previously ordered through the remainder of cert period 11/01/13..." The order stated Patient #14 had been hospitalized for exacerbation of emphysema and ALS.</p> <p>ST visits were documented to Patient #14 on 10/02/13, 10/08/13, and 10/09/13.</p> <p>A "COMMUNICATION NOTE" by the DCS, dated 10/16/13 at 2:06 PM, stated "[Patient #14] was discharged from the Hospital approximately 2</p>	G 143		

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G 143	Continued From page 14 weeks ago on 10/2. We did not receive documentation from the Hospital and I was unaware that she was home until the Speech Therapist called me yesterday and she had been making visits with [Patient #14] all last week without the patient's care being resumed appropriately...The speech therapy visits that were made before care resumed will all be non-billable."  The DCS was interviewed on 12/19/13 beginning at 10:20 AM. She stated care had not been coordinated between SN and ST.  Patient #14's care was not coordinated between SN and ST.	G 143			
G 144	484.14(g) COORDINATION OF PATIENT SERVICES  The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur.  This STANDARD is not met as evidenced by: Based on staff interview, review of medical records and agency policies, it was determined the agency failed to ensure care coordination between disciplines was documented for 1 of 12 patients (#3) who received services from more than one discipline and whose records were reviewed. This had the potential to interfere with the quality and continuity of care provided to all patients who received agency services. Findings include:	G 144	G 144  Communication between All disciplines involved in the Patient's Plan of Care will be clearly documented on the shared communication note. Case conferences will occur during staffing meetings every other week, and will be documented on the shared communication note at least every 4 weeks, and no later than 6 weeks. The communication note will be utilized by team caring for Patient as often as changes occur, and whenever disciplines communicate regarding a Patient. The Director of Clinical		

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G 144	<p>Continued From page 15</p> <p>An agency policy, "CARE COORDINATION," dated 2/12/02, stated "CONTINUITY OF CARE IS DEMONSTRATED BY: ...Telephone calls to the physician and other staff members or caregivers, pertaining to care, are documented on the progress note, or Patient Communications Report, and filed in the patient's chart."</p> <p>The agency did not ensure coordination of care activities were documented as follows:</p> <p>Patient #3's medical record documented an 80 year old female who was admitted to the agency on 7/10/13 and died on 8/29/13. Her diagnoses included diabetes, neuropathy, chronic pain, and polypharmacy. She received SN and PT visits while receiving home health services.</p> <p>Patient #3's "PHYSICAL THERAPY VISIT NOTES," dated 7/19/13, 7/26/13, 8/06/13, and 8/16/13, documented "CARE COMMUNICATION" had taken place with the RN. The notes only contained a box that was checked to indicate communication had taken place. The PT notes stated "Coord care with Case Mgr." None of the notes contained specific documentation as to what was discussed. No nursing notes documented coordination of care with the therapist.</p> <p>The DCS was interviewed on 12/16/13 beginning at 3:10 PM. She stated she was also the CM for Patient #3. She reviewed the record. She confirmed the record did not contain specific documentation of communication between the therapist and nursing staff.</p> <p>Specific documentation of staff communication was not present in the medical record.</p>	G 144	<p>Services is responsible for implementation and orientation of staff. The case manager is responsible for providing appropriate documentation i.e. documenting case conferences on communication note. This will be completed by 1/21/14.</p> <p>See Addendum #6</p>	

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G 151	<p>484.16 GROUP OF PROFESSIONAL PERSONNEL</p> <p>This CONDITION is not met as evidenced by: Based on staff interview and review of meeting minutes, it was determined the agency failed to ensure the group of professional personnel, (the PAC) carried out its duties. This resulted in a lack of oversight and feedback to the agency. Findings include:</p> <p>1. Refer to G153 as it relates to the failure of the agency to ensure the PAC established and annually reviewed agency policies.</p> <p>2. Refer to G154 as it relates to the failure of the agency to ensure the PAC advised the agency on professional issues, participated in the evaluation of the agency's program, and assisted the agency in maintaining liaison with other health care providers.</p> <p>The cumulative effect of these systemic omissions resulted in a lack of involvement by the PAC.</p>	G 151	<p>G 151</p> <p>Refer to G 153, G 154</p> <p>Completion date 1/21/14</p>	
G 153	<p>484.16 GROUP OF PROFESSIONAL PERSONNEL</p> <p>The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an</p>	G 153		

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G 153	<p>Continued From page 17 owner nor an employee of the agency.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of meeting minutes, it was determined the agency failed to ensure the PAC established and annually reviewed the agency's policies. This resulted in a lack of oversight and direction to the agency. Findings include:</p> <p>Two sets of meeting minutes for the year 2013 were provided to surveyors. Both were hand written over an "AGENDA" titled "Semi Annual Meeting." The minutes, dated 7/11/13, stated "Review [with] Carolyn's group Bob. Type up procedure for census. Approx. 10 days out currently (reg 7 day or - 2%). Place another ad for [weekend]. Eval's [DCS name, unknown person's name] Case mgr. Gov website [Assistant Administrator's name]. Policy &amp; Proc [2 names]."</p> <p>The meeting minutes, dated 12/03/13, were also incomplete. They stated "Yearly review completed. P&amp;P ongoing updates." Under the heading "Current Census" was written 51-1 @ recurring. Current @ +2012 [with] Nov &amp; Dec Pndg."</p> <p>The Administrator was interviewed on 12/19/13 beginning at 3:00 PM. She stated the above minutes were the official PAC minutes for the agency for the prior year. She confirmed the minutes were incomplete. She stated no other documentation of the PAC's activities was available. She stated, other than the statement "P&amp;P ongoing updates" from the 12/03/13 minutes, no documentation was present that the</p>	G 153	G 153		
			<p>The PAC has been realigned and will meet at least semi-annually (and more often as needed). The PAC meetings to follow a clear and concise Agenda, including review of the Policy and Procedure updates. The PAC will establish and review agency policies, present changes and/or updates to the Governing Body for approval, and then provide advice and direction to the agency staff during staffing meetings bi-monthly. The PAC will include the scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. Administrator will be responsible for scheduling meetings, preparing agenda, and clearly documenting context of meeting/minutes. Administrator, Assistant Administrator, and the Director of Clinical Services to be responsible for presenting policy updates to the PAC. MultiCare conducted PAC meeting on 1/16/14. Four Governing Board members serve</p>		

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G 153	Continued From page 18 PAC had established or reviewed agency policies.	G 153	on PAC. Five of six Governing Body members reviewed and approved as of 1/20/14. There is no anticipation that major changes to content will be made at the formal review at Governing Body meeting 2/27/14.		
G 154	The PAC failed to establish and review policies. 484.16(a) ADVISORY AND EVALUATION FUNCTION  The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in the agency's community information program.  This STANDARD is not met as evidenced by: Based on staff interview and review of meeting minutes, it was determined the agency failed to ensure the PAC advised the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers. This resulted in a lack of feedback to the agency. Findings include:  The policy "PROFESSIONAL ADVISORY COMMITTEE," dated 12/02/02, stated the purpose of the PAC was to advise the agency on professional and community issues, participate in the development and evaluation of the agency's policies, and assist the agency in maintaining liaison with other health care providers. These activities were not documented.  Two sets of meeting minutes for the year 2013 were provided to surveyors. Both were hand written over an "AGENDA" titled "Semi Annual	G 154	See Addendum #1, #2, #3 and #9		

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G 154	Continued From page 19 Meeting." The minutes were dated 7/11/13, and 12/03/13. Neither set of minutes mentioned the PAC directly. Neither set of minutes documented the PAC provided advice or direction to the agency.  The Administrator was interviewed on 12/19/13 beginning at 3:00 PM. She stated the above minutes were the official PAC minutes for the agency for the prior year. She confirmed the minutes did not document that the PAC had advised or provided assistance to the agency. She stated no other documentation of the PAC's activities was available.	G 154			
G 156	The PAC failed to complete its required duties. 484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  This CONDITION is not met as evidenced by: Based on staff and patient interview, observation, review of medical records and agency policies, it was determined the agency failed to ensure POCs were developed, followed, and updated. These failures had the potential to result in unmet patient needs and negatively impact the continuity, safety, and quality of patient care. Findings include:  1. Refer to G157 as it relates to the agency accepting patients with therapy needs that could not be met.  2. Refer to G158 as it relates to the failure of the agency to ensure care followed the written POC.	G 156	G 156  Refer to: G 157, G 158, G 159, G 160,  G 164  Completion date 1/21/14		

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G 156	Continued From page 20  3. Refer to G159 as it relates to the failure of the agency to ensure all pertinent diagnoses were addressed in patients' POCs.  4. Refer to G 160 as it relates to the failure of the agency to consult the physician to approve the POC.  5. Refer to G164 as it relates to the failure of the agency to notify the physician with changes in patients' condition.  The cumulative effect of these negative systemic practices impeded the agency in providing quality care in accordance with established POC's.	G 156			
G 157	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence.  This STANDARD is not met as evidenced by: Based on staff interview and medical record review, it was determined the agency failed to ensure ST and OT services were available to 2 of 10 patients (#11 and #14) who had those services ordered and whose records were reviewed. This resulted in the inability of the agency to carry out the POC. Findings include:  1. Patient #14's medical record documented a 65 year old female who was admitted to home health	G 157	G 157  MultiCare will orient Case Managers, and contracted staff to Policy and Procedure and appropriate documentation regarding acceptance of a Patient for all services that have been ordered for Home Health Care, and timely provision of services as noted in Policy and Procedure. The Case Manager will document on the communication note in the Patient's clinical record any and all reasons for delay in service. The PCP will be notified of the delay and the reasons for the delay in service (to be Patient		

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G 157	<p>Continued From page 21</p> <p>care on 5/06/13 and transferred to hospice care on 10/30/13. Her diagnoses included motor neuron disease and COPD.</p> <p>Patient #14's record contained a physician order, dated 5/15/13 at 6:44 PM, for ST one visit every other week. ST visits were not documented.</p> <p>A "SKILLED NURSE VISIT NOTE," dated 6/13/13 at 7:30 PM, stated Patient #14 had been hospitalized from 6/09/13 until 6/13/13 for a brain hemorrhage following a fall. The note stated "Her speech is slightly slurred however about the same as she was before this event. She is to start using applesauce or pudding to swallow medications and is well with this. She will now be getting ST for [oral] E-Stim treatments to start the first of next week."</p> <p>An ST evaluation was not documented until approximately 2 months later, on 8/13/13.</p> <p>The DCS was interviewed on 12/19/13 beginning at 10:20 AM. She confirmed the lack of ST services. She stated the therapy company the agency contracted with for ST services did not have ST available when it was ordered. The DCS stated Patient #14's physician had been informed of the lack of ST services and the inability to carry out the orders but she stated this was not documented.</p> <p>The Speech Therapist was interviewed on 12/19/13 beginning at 1:25 PM. She stated she worked for a therapy agency that contracted with Multicare Home Health. She stated her availability to provide services to Multicare depended on her other commitments to the therapy agency. She stated if she could not see</p>	G 157	<p>related and not Clinician related) with supporting documentation on the Patient's clinical record. The agency will not accept a Patient referral unless they can provide all services ordered per PCP, unless Patient has declined a service or has been determined not to require that service in the home per the case manager's initial evaluation and approval of PCP. The case manager will initiate a start of care order on the SOC date, and will call the PCP to receive verbal orders for the care that is to be provided to the Patient. The case manager will include this verbal order on start of care order, including who gave the order, and that visits have been approved from the start of care date until the signed Plan of Care has been returned to the agency. The Director of Clinical Services will be responsible for orientation of case managers, and contracted staff regarding acceptance of Patients, and PCP orders. This will be completed by 1/21/14.</p> <p>See Addendum #10 and #11</p>		

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G 157	<p>Continued From page 22</p> <p>a new patient for a few days then her agency would not accept the referral.</p> <p>The home health agency failed to meet Patient #14's ST needs.</p> <p>2. Patient #11 was a 70 year old female, admitted to the agency on 10/21/13 for care related to DM II, neuropathy, HTN, A-Fib, and morbid obesity. A comprehensive assessment was completed on 10/21/13 and the POC was implemented. The POC was signed by the physician on 11/06/13.</p> <p>A form titled "DOCTORS ORDERS," dated 10/21/13, noted "Requesting a start of care order for home health services for period 10/21/13-12/19/13." The form noted services would be provided by SN, PT, OT, MSW, and CNA (Home Health Aide), but did not indicate frequency of visits. The form was signed by the physician 11/06/13.</p> <p>The POC for the certification period 10/21/13 to 12/19/13 did not include orders for OT, although the "DOCTORS ORDERS," signed 11/06/13 indicated OT was ordered.</p> <p>An OT Evaluation was completed on 11/12/13, however there was no documentation in Patient #11's medical record to indicate a reason for the delay.</p> <p>During an interview on 12/19/13 beginning at 2:00 PM, the DCS stated the Occupational Therapist had a full time job during daytime hours and was only able to work for the HHA evenings and on weekends.</p> <p>The agency did not meet Patient #11's therapy</p>	G 157		

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G 157	Continued From page 23 needs.	G 157		
G 158	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure care followed a written POC for 6 of 14 patients (#4, #8, #9, #11, #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 and treatment administration without an order, medications not administered and additional therapy visits that were not ordered. Findings include:</p> <p>1. Patient #4's medical record documented an 87 year old female admitted to the agency on 2/27/13 with diagnoses including A-fib, HTN, CVA, dementia and history of recent falls. Her medical record for the certification period of 2/27/13 through 4/27/13 was reviewed. Medications and treatments were not provided in accordance with the POC as follows:</p> <p>a. An LPN visit note, dated 4/02/13, documented Patient #4 had a sore to her right middle toe. The LPN documented Patient #4 stated her middle toe was very painful when touched. The LPN documented the right middle toe had a sore with a scab on it and the toe was red and swollen. The LPN visit note dated 4/02/13 documented</p>	G 158	<p>G 158</p> <p>MultiCare will ensure that care provided to a Patient is in accordance with the Plan of Care, and any additional orders written for the Patient after the Plan of Care. The RN case manager will instruct LPN prior to LPN providing care to a Patient regarding the Plan of Care, and provide the LPN with a copy of the Plan of Care, and any additional orders for a Patient if they occur. The RN case manager will instruct LPN to call the case manager if there are any changes in the Patient's status (i.e.: medications, open skin, constipation), and too enter a communication note with a description of change. The RN case manager will call the PCP to receive a verbal order for a treatment if needed, or clarification of a med change, and then send an order to the PCP including the verbal order on the written order. The case manager will initiate a start of care order on SOC date, and will call the PCP to receive verbal orders for the care that is too</p>	

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G 158	<p>Continued From page 24</p> <p>she notified the CM. There was no documentation to indicate Patient #4's physician had been notified of the wound.</p> <p>An RN visit note, dated 4/04/13, documented the RN assessed the wound on Patient #4's toe. The RN documented that when she removed the Band-Aid that was covering the wound, the top layer of the scab came off with the Band-Aid, leaving a "crater with yellow slough in the wound bed in the very center? Possible bone as it is right over the first joint, with beefy red tissue surrounding the slough." The RN documented the wound was 0.7 cm in diameter. The RN also documented she would obtain an order for wound care. However, there was no documentation to indicate the physician was notified of the wound, or a wound care order was received.</p> <p>An LPN visit note, dated 4/08/13, documented the LPN removed a dressing to Patient #4's right middle toe and noted a small amount of serosanguinous exudate on the dressing. The LPN noted the wound had formed a small crater in the interior of the wound. The LPN documented that after "spraying [the wound] with MicroKlense, it did start to bleed. I washed it out with sterile saline and put in powder/gel and placed a foam dressing on top and used hyperfix tape to hold the dressing in place. I then checked her skin and discovered that she had small developing ulcer on her left buttocks area. I sprayed it with hyperfix and placed a foam dressing over with hyperfix tape." There was no documentation to indicate Patient #4's physician was notified of the new ulcer to Patient #4's buttocks, or orders for the wound care noted above, were received. In addition, there was still no documentation to indicate the physician was</p>	G 158	<p>be provided to the Patient. The case manager will include this verbal order on her start of care order, including who gave the order, and that visits have been approved from the start of care date until the signed PLAN OF CARE has been returned to the agency. The RN case manager will communicate with other services involved in the Patient's PLAN OF CARE, and let the service (i.e.: Therapy services, Home Health Aide) know if the Patient has been admitted to the Hospital, and that they cannot resume care of Patient until a Resumption of Care has been done per the RN case manager. The shared communication note will be utilized by all services to ensure continuity of care. The Director of Clinical Services will be responsible for orientation of case managers, LPN's, and contracted staff regarding following the Plan of Care, and PCP orders. This will be completed by 1/21/14.</p> <p>See Addendum #11</p>	

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G 158	<p>Continued From page 25</p> <p>notified of the wound to Patient #4's toe, nor was there documentation of orders to provide wound care.</p> <p>A "DOCTORS ORDERS" form, dated 4/08/13, documented an order request, which stated "Stage I pressure area on left buttock has now become a stage II on 4/08/13, we are cleaning it, applying protective cream and covering it with Copa foam and hypofix tape. Change twice a week and PRN." The order request did not specify how the wound was being cleaned. There was no documentation in the record to indicate a stage I pressure ulcer had been identified prior to 4/08/13, so it was unclear at what point the stage I appeared and/or changed to a stage II ulcer. The physician did not sign the request, which then initiated the order, until 4/13/13, five days after the ulcer was discovered.</p> <p>Prior to obtaining the physician's signed order on 4/13/13, wound care was again provided to the ulcer on Patient #4's left buttock and right middle toe. The LPN documented the wound to Patient #4's toe now measured 1 cm in diameter and was 2 cm deep. She documented the toe was red and painful to touch. The LPN documented she cleaned and dressed the toe, securing the dressing with hypofix tape. The LPN documented she assessed the ulcer to Patient #4's left buttock and noted "the foam dressing that I had placed on the open wound was off and it revealed a surface depth peel of skin at about 2 cm around. The wound bed was red. I sprayed it with hypofix and placed a foam dressing over it for protection."</p> <p>An RN visit, dated 4/16/13, documented the RN performed wound care to Patient #4's toe using "skin prep and apply multidex powder to the</p>	G 158		

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G 158	<p>Continued From page 26</p> <p>wound bed, apply copa foam secure with hypofix tape..." The RN also documented she cleansed and redressed the pressure ulcer to Patient #4's left buttock. There was no documentation to indicate an order was procured for the wound care on Patient #4's toe.</p> <p>On 4/17/13, the RN submitted an order request to Patient #4's physician, stating "Left toe wound on 4/2/13 presented with dry scab, a clean dry dressing was placed over the wound. On 4/4/13 the wound was assessed/cleaned and the scab/top layer of skin came off and left a small crater over the first joint. Using clean technique I cleaned the wound then multidex powder was puffed in to the wound bed, then covered with Copa foam and secured with hypofix tape. Change twice weekly and dc when healed." The physician signed the request, generating an order on 4/17/13, 15 days after the wound was first discovered.</p> <p>The DCS reviewed the record and was interviewed on 4/18/13 beginning at 2:00 PM. She confirmed there was no documentation to indicate orders had been received for wound care to Patient #4's left buttock pressure ulcer and toe wound prior to 4/13/13 and 4/17/13, respectively. She stated the RN had received verbal orders for wound care, but confirmed this was not documented, and therefore wound care to Patient #4's toe and buttock was provided without orders.</p> <p>Wound care was provided without an order.</p> <p>b. A "DOCTORS ORDERS" form, dated 2/27/13, documented an order request stating "Please clarify the Prozasin [sic] 5 mg cap, rehab dc order is for once daily and you have her listed as taking</p>	G 158			

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G 158	<p>Continued From page 27</p> <p>it BID. Which dosing schedule would you like her to utilize?" The order request was signed by the physician on 3/05/13, but did not contain documentation of the physician's preferred dosing of the Prazosin.</p> <p>The POC documented Prazosin HCL 5 mg to be taken orally, twice a day. There was no documentation to indicate further contact with the physician had been made to clarify the order.</p> <p>The DCS reviewed the the record and was interviewed on 12/18/13 at 2:00 PM. She confirmed there was no documentation to indicate the order had been clarified with the physician to determine the correct dosing frequency for the Prazosin HCL.</p> <p>Medications were included on the POC without physician clarification.</p> <p>2. Patient #8's medical record documented a 70 year old female admitted to the agency on 10/04/13 with diagnoses including lumbar sprain, back pain, and emphysema. Her medical record for the certification periods of 10/04/13 through 12/02/13, and 12/03/13 through 1/31/14, were reviewed.</p> <p>An LPN visit note, dated 11/07/13, documented Patient #8 had not had a BM in 6 days and "had gotten MOM to take although it was unopened. I went ahead and administered 30 mg to her while I was there..." There was no documentation to indicate an order was received for the MOM.</p> <p>An LPN visit note, dated 11/14/13, documented Patient #8 continued to experience constipation and had taken magnesium citrate in addition to</p>	G 158		

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G 158	<p>Continued From page 28</p> <p>the MOM. There was no documentation to indicate an order had been received for the magnesium citrate.</p> <p>An LPN visit note, dated 11/27/13, documented Patient #8 continued to experience constipation and had not had a BM in 4 days. She documented Patient #8 was taking Ex-Lax in addition to the MOM and magnesium citrate. The LPN documented Patient #8 would be seeing her physician on 12/03/13 to update him on her condition. There was no documentation to indicate an order had been received from Patient #8's physician for the Ex-Lax.</p> <p>The DCS reviewed the record and was interviewed on 12/18/13 at 2:00 PM. She confirmed there was no documentation to indicate orders had been received from Patient #8's physician for the use of the of multiple laxatives.</p> <p>Laxatives were administered to Patient #8 without an order.</p> <p>3. Patient #9's medical record documented a 75 year old female admitted to the agency on 4/05/13 with diagnoses including chronic bronchitis, CHF, CAD, and HTN. Her medical record for the certification period of 4/05/13 through 6/03/13, was reviewed. Patient #19 was discharged from the agency on 4/23/13.</p> <p>A "DOCTORS ORDERS" form, generated by the agency, dated 4/05/13, included an order request for SN to evaluate, treat, admit Patient #9 to care, and develop the POC. The form also included a request for PT to evaluate and treat. There was no documentation to indicate a verbal order was</p>	G 158		

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G 158	<p>Continued From page 29 obtained to start care for Patient #9.</p> <p>The physician signed the request on 4/19/13, generating the order for the start of care. However, Patient #9 had already been receiving SN services prior to receiving the signed order. The medical record documented Patient #9 received SN visits on 4/11/13 and 4/16/13.</p> <p>The DCS reviewed the record and was interviewed on 12/18/13 at 1:15 PM. She confirmed there was no documentation to indicate a verbal order had been received for the start of care. She confirmed that without a verbal order, SN visits made prior to 4/19/13 were made without an order.</p> <p>SN visits were provided without a physician order.</p> <p>4. Patient #13's medical record documented a 76 year old male admitted to the agency on 10/28/13 with diagnoses including shoulder dislocation after a fall, HTN, and dysmetabolic syndrome. His medical record for the certification period of 10/28/13 through 12/26/13 was reviewed.</p> <p>The POC, signed by the physician but not dated, documented MSW visits were to be made twice a month for one month to assist Patient #13 with accessing resources to allow him to remain safely in his home.</p> <p>An MSW visit was made to Patient #13's home on 11/06/13. The MSW documented Patient #13 needed assistance with housekeeping and shopping, and assistance with applying for Medicaid, food stamps, emergency assistance and energy assistance. The MSW documented she assisted Patient #13 in completing an</p>	G 158		
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NAME OF PROVIDER OR SUPPLIER  <b>MULTICARE HOME HEALTH SERVICES, INC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>324 SOUTH MERIDIAN RD, SUITE 10 MERIDIAN, ID 83642</b>
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G 158	<p>Continued From page 30</p> <p>application for Medicaid. There was no documentation to indicate assistance with the other needs identified.</p> <p>There were no further MSW visits documented in the medical record at the time of the survey on 12/18/13. There was no documentation by the MSW indicting the status of Patient #13's Medicaid application or any other resources available to him. There was no documentation to indicate the physician had been notified of the MSW's inability to provide 2 visits per month in accordance with the POC.</p> <p>The CM reviewed the record and was interviewed on 12/19/13 at 8:10 AM. She confirmed the MSW had not made 2 visits per month in accordance with the POC. She confirmed there was no documentation from the MSW indicating the status of Patient #13's Medicaid application. She stated Patient #13 had been denied Medicaid. She also stated the MSW "really couldn't do anything for him because he makes too much money" and therefore had not continued to see Patient #13.</p> <p>MSW visits were not provided in accordance with the POC.</p> <p>5. Patient #11 was a 70 year old female, admitted to the agency on 10/21/13 for care related to DM II, neuropathy, HTN, A-Fib, and morbid obesity. A comprehensive assessment was completed on 10/21/13 and the POC was implemented. The POC was signed by the physician on 11/06/13.</p> <p>Patient #11's comprehensive assessment, dated 10/21/13 noted she was an insulin dependent</p>	G 158		
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G 158	<p>Continued From page 31</p> <p>diabetic, and had neuropathy of both feet which resulted in difficulty with ambulation and was at risk for falls.</p> <p>A nursing visit note, dated 11/11/13 from 3:30 to 4:30 PM, described Patient #11 as having pain and swelling in her right great toe. The toe was noted to be red to the second joint and warm to the touch. The RN noted she was able to express infectious material from under the toenail. She documented Patient #11's foot was soaked in a warm salt bath and then she trimmed her toenails. The RN noted she instructed Patient #11 to soak her feet in warm salt water several times a day until further instructed by the physician. The wound on Patient #11's left thigh was documented as "...now progressed to an unstageable ulcer, covered with yellow slough." The nursing note did not document physician notification regarding the progression of Patient #11's thigh wound, the infection under her right toenail, or to receive orders for the warm salt baths and foot care.</p> <p>During an interview on 12/19/13 beginning at 10:00 AM, the RN reviewed Patient #11's record and stated she had instructed Patient #11 to make an appointment with a podiatrist. She was unable to determine if the ordering physician on the POC was aware of that referral.</p> <p>Patient #11 received treatments and referral to an additional practitioner which were not included on her POC.</p> <p>6. Patient #14's medical record documented a 65 year old female who was admitted to home health care on 5/06/13 and transferred to hospice care</p>	G 158			

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G 158	<p>Continued From page 32 on 10/30/13. Her diagnoses included motor neuron disease and COPD.</p> <p>Patient #14's "DOCTORS ORDERS," dated 10/16/13 at 2:06 PM, stated "Patient was hospitalized from 9/30/13 to 10/02/13, however we were not informed of her discharge and did not receive documentation from [discharge] until today...Orders: Resume Home Health Services for SN and ST as previously ordered through the remainder of cert period 11/01/13..." The order stated Patient #14 had been hospitalized for exacerbation of emphysema and ALS.</p> <p>ST visits were documented to Patient #14 on 10/02/13, 10/08/13, and 10/09/13. No orders were present authorizing these visits.</p> <p>The Speech Therapist was interviewed on 12/19/13 beginning at 1:25 PM. She confirmed she had made visits to Patient #14 before a POC had been developed. She stated she knew Patient #14 had been hospitalized but said she thought the DCS had reinstated the patient after hospitalization. She stated she now knew to check with the CM prior to making visits.</p> <p>ST visits were not made to Patient #14 in accordance with the POC.</p>	G 158		
G 159	<p>484.18(a) PLAN OF CARE</p> <p>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</p>	G 159	<p>G 159</p> <p>MultiCare will ensure that the Plan of Care covers all pertinent diagnoses, types of services required, equipment, supplies, functional limitations, treatments, activities permitted, nutritional requirements,</p>	

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G 159	<p>Continued From page 33</p> <p>safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>This STANDARD is not met as evidenced by: Based on record review, staff interview, observation and patient interviews during home visits, it was determined the agency failed to ensure POCs covered all pertinent diagnoses types of services required, equipment, supplies, functional limitations, treatments and reporting parameters for 9 of 14 patients (#1- #6, #8, #12, #13) whose records were reviewed. This resulted in a lack of direction to staff caring for those patients. Findings include:</p> <p>1. Patient #3's medical record documented an 80 year old female who was admitted to the agency on 7/10/13 and died on 8/29/13. Her diagnoses included diabetes, neuropathy, chronic pain, and polypharmacy.</p> <p>A "DISCHARGE SUMMARY" from a local hospital, dated 7/04/13 and faxed to the agency on 7/09/13, stated Patient #3 had been admitted to the hospital for delirium on 7/03/13 and was discharged on 7/04/13. The summary stated Patient #3's delirium cleared quickly with medication oversight. The summary stated Patient #3's son searched her room after she was admitted and "...found several 'stashes' of over-the-counter sleep aids as well as extra Norco which he thinks she was likely taking. This has been a problem in the past as well...I have requested home health services with a visiting nurse to assist with medication management and compliance and assistance to set up a system to avoid further misuse."</p>	G 159	<p>medications, treatments, and any safety measures to protect against injury, instructions for timely discharge and any other appropriate items. Director of Clinical Services will orient the RN case managers developing the Plan of Care to cover all pertinent dx, medications, treatments, durable medical equipment (DME), interventions that are Patient specific (i.e.: medication security, extreme fall risk, lymphedema tx, parameters for blood pressure, parameters for hypo/hyperglycemia, O2) that are ordered per the PCP. The RN case manager will update the Plan of Care if changes occur during the certification period, if the Patient is being recertified, and if care is being resumed following an inpatient stay. The Director of nursing will orient the RN case manager and LPN's to follow the Plan of Care including durable medical equipment (DME) listed on Plan of Care, and if durable medical equipment (DME) is new in the home the RN case manager will call PCP to clarify and then send an order for the</p>	

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G 159	<p>Continued From page 34</p> <p>Patient #3's POC for the certification period from 7/10/13 to 9/07/13 stated Patient #3 was to receive 1-2 nursing visits per week for 9 weeks. The only mention of monitoring and oversight of medications on her POC stated "Assess as needed: Comprehensive system assessment, s/sx dehydration, pain and symptom control, peripheral vascular status, edema, activity tolerance, fatigue level, response to medications, medication compliance, vital signs, nutritional status, ADL status, Psych/spiritual needs of illness, ability to remain safely in the home with intermittent family assistance and progression with therapy services, mental status changes, skin integrity, s/sx infection, BG levels." No other direction to staff was provided on the POC.</p> <p>Nursing visits were documented on 7/10/13, 7/17/13, 7/24/13, 8/05/13, 8/14/13, and 8/21/13. The "SKILLED NURSE VISIT NOTE," dated 8/05/13 at 3:30 PM, stated Patient #3 "...is having a hard time with not having control of her medications." No nursing notes documented assessing Patient #3's medication delivery and storage systems.</p> <p>A "COMMUNICATION NOTE," completed by the CM, dated 8/27/13 at 5:37 PM, stated "Patient's son reported to us that [Patient #3] had 'red matter' in her stool, and then spit up and had 'red matter' in her sputum. She was very weak. He checked her medication and realized that she had access to her aspirin and had taken over '100 tabs' over the past 2 weeks. He has been managing her medications and dosing her for pain according to the prescription, however, [Patient #3] has stated she was not covered for her pain and somehow got a hold of the bottle of</p>	G 159	<p>new durable medical equipment (DME). Any changes that occur will also be documented on the communication note per the discipline that finds the change at time of their visit with the Patient. This will ensure that all the Patient's pertinent Home Health needs are being met effectively. This will be monitored by the Director of Clinical Services , and the RN case manager of the Patient at start of care, anytime a change in treatment occurs, change in Patient's condition, and medications, and at recertification, and resumption of care if indicated. This will be completed by 1/21/14.</p> <p>See Addendum #12</p>	

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G 159	<p>Continued From page 35</p> <p>aspirin and was taking this as pain relief causing internal bleeding. She was admitted to the hospital and is currently on CCU."</p> <p>The DCS was interviewed on 12/16/13 beginning at 3:10 PM. She stated Patient #3 hoarded her medications. She stated Patient #3 hid her medications and took them inappropriately. She stated Patient #3's son moved in with her at the start of care and managed her medications. She confirmed Patient #3's POC did not address medication security. She stated, since Patient #3's son was managing her medications, she trusted him to provide security.</p> <p>Patient #3's POC did not cover medication security.</p> <p>2. Patient #1's medical record documented an 85 year old female who was admitted to the agency on 7/15/13 and discharged on 10/29/13. The record stated she was admitted to a skilled nursing facility on 10/07/13. She did not return to home health care after admission. Her diagnoses included fractured lumbar vertebra, osteoporosis, and diabetes.</p> <p>A "PHYSICAL THERAPY EVALUATION," dated 7/16/13 at 4:15 PM, stated Patient #1 was admitted following a compression fracture of her back after a fall. The evaluation stated Patient #1 lived alone and her daughter lived across the street. The evaluation stated Patient #1 was a "...very high fall risk...and at this time is unable to safely care for herself in her home."</p> <p>A "SKILLED NURSE VISIT NOTE," dated 7/19/13 at 1:00 PM, stated Patient #1 fell on 7/18/13.</p>	G 159		

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G 159	<p>Continued From page 36</p> <p>A "COMMUNICATION NOTE" by the DCS, dated 7/23/13 at 4:24 PM, stated Patient #1 fell and was taken to a local emergency department after a fall but was not admitted. The note stated she was diagnosed with a closed left hip fracture. The note stated there was nothing to be done except pain management. The note stated Patient #1's daughter arranged for a private caregiver for 2 hours in the mornings during the week but the patient refused additional care.</p> <p>A "PHYSICAL THERAPY VISIT NOTE," dated 8/12/13 at 3:00 PM, stated Patient #1 was not safe with many of the activities she does in her home. A "PHYSICAL THERAPY VISIT NOTE," dated 8/19/13 at 3:00 PM, stated "It is a concern that I have found pt on the toilet twice now unable to get her pants on. Spoke to pt about being alone and how unsafe it is for her."</p> <p>A "COMMUNICATION NOTE" by the LPN, dated 8/27/13 at 5:08 PM, stated Patient #1 was found on the floor when the LPN made a home visit. The note said Patient #1 stated she had been on the floor for about 30 minutes.</p> <p>A "COMMUNICATION NOTE" by the OT, dated 9/01/13 at 4:13 PM, also stated Patient #1 was found lying on the floor. The note stated she was taken to the emergency department. It did not state how long the patient had been down.</p> <p>Patient #1's POCs for the certification periods 7/15/13 to 9/12/13 and 9/13/13 to 11/11/13 both stated a nurse would visit 1-2 times a week for 9 weeks with 2 as needed visits for "...fall with injury." Both POCs directed nurses to teach fall prevention measures as needed. Both POCs directed physical therapists to "Teach fall safety."</p>	G 159		

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G 159	<p>Continued From page 37</p> <p>Neither POC addressed Patient #1's extreme fall risk or her need for 24 hour supervision.</p> <p>The DCS was interviewed on 12/19/13 beginning at 9:25 AM. She stated Patient #1 was admitted to home health services after a fall which fractured a vertebra. She stated Patient #1's daughter lived across the street but said the daughter worked full time. She stated Patient #1 needed 24 hour supervision. She stated Patient #1's posture was very hunched over and she had an extremely unsteady gait. She confirmed Patient #1's POC did not address her severe fall risk and lack of supervision.</p> <p>Patient #1's POC did not cover her extreme fall risk or lack of supervision.</p> <p>3. Patient #12's medical record documented a 21 year old female who was admitted to the agency on 10/21/13 and discharged on 12/18/13. Her diagnoses included a kidney transplant on 9/14/13, non-healing surgical wound, depression, and newly diagnosed diabetes.</p> <p>An email from the transplant center, dated 10/04/13 and faxed to the agency on 10/18/13, stated Patient #12 "...was discharged [from hospital] on 10/04/13, following a 4 day stay for hyperglycemia and wound infection. Patient's blood sugar on admission was 945 and an insulin drip was initiated." Also, a "PHYSICIAN FACE TO FACE ENCOUNTER" form, dated 10/18/13 and faxed to the agency on 10/21/13, stated "Patient is immunosuppressed and needs to avoid situations that can contribute to illness or infection."</p> <p>Patient #12's POC for the certification period</p>	G 159		
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G 159	<p>Continued From page 38</p> <p>10/21/13-12/19/13 did not provide guidance to the nurse regarding treatment of her diabetes except to state her insulin dosage. The POC did not address glucose testing or parameters to notify the physician if her blood glucose level was too high or too low. In addition, the POC did not address Patient #12's immunosuppression.</p> <p>Patient #12's CM was interviewed on 12/19/13 beginning at 8:40 AM. She reviewed the record and confirmed the POC did not address Patient #12's diabetes and immunosuppression.</p> <p>Patient #12's POC did not cover her diabetes and immunosuppression.</p> <p>4. Patient #6's medical record documented an 89 year old female admitted to the agency on 9/18/13 with diagnoses of COPD, CHF, and anemia. Her medical record for the certification period of 11/17/13 through 1/15/14 was reviewed. Her POC for this certification period did not include all pertinent treatments and equipment as follows:</p> <p>a. The "OASIS-C NURSE RECERTIFICATION" assessment, dated 11/15/13, documented Patient #6 was to be weighed daily, per her daughter, and her physician was to be notified for a weight variance of 5 pounds.</p> <p>The POC documented to "perform as needed: Notify MD of complications, Check weight 1 x week...." The POC documented SN frequencies as 2-3 times a week for 9 weeks.</p> <p>During an observation of an LPN visit on 12/18/13, beginning at 11:00 AM, the LPN stated weights were to be taken weekly, but that Patient</p>	G 159		

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G 159	<p>Continued From page 39</p> <p>#6's daughter had been taking weights daily and documenting this in a book. The LPN stated the nurses check the book on each visit and were to notify the physician for a weight gain of 5 pounds or more.</p> <p>The DCS, who was also the CM for Patient #6, reviewed the record and was interviewed on 12/18/13 at 1:25 PM. She confirmed the POC did not accurately reflect the frequency of weights taken for Patient #6. She stated that Patient #6's weight was being assessed at every visit by checking the weight that had been documented by Patient #6's daughter. She also confirmed the POC also did not include parameters for when to notify the physician of a change in Patient #6's weight.</p> <p>b. LPN visits notes, dated 12/04/13 and 12/02/13, documented Patient #6 had compression stockings to reduce swelling but she refused to wear them. The compression stockings were not included on the POC.</p> <p>The DCS, who was also the CM for Patient #6, confirmed Patient #6 had compression stockings, but only wore them when she had edema to her lower extremities. She confirmed the compression stocking were not included on the POC.</p> <p>The POC did not include all treatments and equipment needed to care for Patient #6.</p> <p>5. Patient #13's medical record documented a 76 year old male admitted to the agency on 10/28/13 with diagnoses including shoulder dislocation after a fall, HTN, and dysmetabolic syndrome. His medical record for the certification period of</p>	G 159			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  12/20/2013
NAME OF PROVIDER OR SUPPLIER  MULTICARE HOME HEALTH SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 324 SOUTH MERIDIAN RD, SUITE 10 MERIDIAN, ID 83642		
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G 159	<p>Continued From page 40 10/28/13 through 12/26/13 was reviewed.</p> <p>His POC for the above certification period, signed by the physician but not dated, included a goal that Patient #13's BP would be less than 160/90. There was no documentation on the POC to indicate BP parameters for which to notify the physician.</p> <p>On 11/04/13, the CM documented Patient #13's BP was 158/92. There was no documentation to indicate she notified the physician of this BP reading.</p> <p>The CM reviewed the record and was interviewed on 12/19/13 at 8:10 AM. She stated she considered anything above 160/90 to be the parameters to call the physician, though she confirmed there was no documentation on the POC specifically stating this. She confirmed she did not call the physician about the BP reading taken 11/04/13, despite the diastolic pressure of 92 exceeding the "parameter" of 90. She then stated that 160/90 was just a goal and not necessarily parameters for when to call the physician.</p> <p>The POC did not contained BP parameters.</p> <p>6. Patient #8's medical record documented a 70 year old female admitted to the agency on 10/04/13 with diagnoses including lumbar sprain, back pain, and emphysema. Her medical record for the certification periods of 10/04/13 through 12/02/13 and 12/03/13 through 1/31/14 were reviewed. The POCs for the certification periods did not include all equipment necessary to care for Patient #8 as follows:</p>	G 159			

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G 159	<p>Continued From page 41</p> <p>a. The POC for the certification period 10/04/13 through 12/02/13 documented Patient #8 was dependent on supplemental oxygen and included "oxygen concentrator" under DME. However, documentation related to the amount and manner in which oxygen was supplied to Patient #8 was not included on the POC. The POC medication section noted Patient #8 was on "Medical air 2 LPM via NC continuous inhaled."</p> <p>The POC for the certification period of 12/03/13 through 1/31/14 also documented Patient #8 was dependent on supplemental oxygen, and included "oxygen concentrator" under DME, but oxygen was not included in the medication section of the POC. The POC again noted Patient #8 was on "Medical air 2 LPM via NC continuous inhaled" in the medication section.</p> <p>An observation of a PTA visit was made at Patient #8's home on 12/18/13 at 9:30 AM. It was noted Patient #8 was on continuous oxygen via NC at 2 LPM during the visit. Patient #8 confirmed she used oxygen continuously and did not use medical air.</p> <p>The DCS reviewed the record and was interviewed on 12/18/13 at 2:00 PM. She confirmed medical air was not an accurate treatment for Patient #8. She confirmed the POCs did not include Patient #8's use of oxygen via NC at 2 LPM despite identifying Patient #8 was dependent on supplemental oxygen.</p> <p>b. The POCs for the certification periods of 10/04/13 through 12/02/13 and 12/03/13 through 1/31/14 both document DME as bath bench, nebulizer, oxygen concentrator, walker, and wheelchair. However, additional DME not</p>	G 159		
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G 159	<p>Continued From page 42 included on the POC was noted as follows:</p> <ul style="list-style-type: none"> <li>- An LPN visit note, dated 11/27/13, documented Patient #8 had a toilet riser and grab pole next to the bed.</li> <li>- An LPN visit note, dated 11/14/13, documented Patient #8 had a toilet bench and riser.</li> <li>- An LPN visit note, dated 10/16/13, documented Patient #8 had a cane and a power chair.</li> <li>- An LPN visit note, dated 10/09/13, documented Patient #8 had a scooter.</li> <li>- A "PHYSICAL THERAPY EVALUATION," dated 10/09/13, documented Patient #8 "uses scooter and power w/c for mobility..."</li> </ul> <p>The DCS reviewed the record and was interviewed on 12/18/13 at 2:00 PM. She confirmed the equipment noted on the LPN notes and PT evaluation were not included on the POCs as DME.</p> <p>Patient #8's POCs did not include all pertinent treatments and equipment.</p> <p>7. Patient #4's medical record documented an 87 year old female admitted to the agency on 2/27/13 with diagnoses including A-fib, HTN, CVA, dementia and history of recent falls. Her medical record for the certification period of 2/27/13 through 4/27/13 was reviewed.</p> <p>The POC, signed by the physician 3/12/13, documented Patient #4 had a walker, wheelchair, leg brace and "Other" as DME. There was no documentation to indicate what "Other" referred to. Additional DME, not included on the POC, was noted as follows:</p> <ul style="list-style-type: none"> <li>- An LPN visit note, dated 3/13/13, documented</li> </ul>	G 159		

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G 159	<p>Continued From page 43</p> <p>Patient #4 had "bars" and a toilet riser.</p> <ul style="list-style-type: none"> <li>- LPN visits notes dated 3/20/13, 3/27/13, 4/08/13, 4/11/13 documented Patient #4 had a toilet riser.</li> <li>- An LPN visit note, dated 4/02/13, documented Patient #4 had a bath bench and cane.</li> </ul> <p>The DCS reviewed the record and was interviewed on 12/18/13 at 2:00 PM. She confirmed the equipment noted on the LPN notes had not been included on the POC as DME.</p> <p>The POC did not include all equipment required to care for Patient #4.</p> <p>8. Patient #2 was a 55 year old female admitted to the agency 7/10/13 for SN and therapy services related to a non-healing surgical wound on her back. Additional diagnoses included DM II, depression, gait abnormality, and seizure disorder.</p> <p>a. A comprehensive assessment was completed 7/12/13, and the POC was developed. Included on the POC for the certification period 7/10/13 to 9/07/13 were wound care items, a walker and a cane.</p> <p>Review of Patient #2's physical therapy and nursing records noted additional equipment which included a brace for her back, bath bench, a bone stimulator, and a glucometer. The items were not included on the POC.</p> <p>During an interview on 12/19/13 beginning at 10:00 AM, the RN who had performed the comprehensive assessment and developed the POC reviewed Patient #2's record and confirmed she had not included the equipment on the POC.</p>	G 159		

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G 159	<p>Continued From page 44</p> <p>b. A transfer form was completed on 7/19/13, which documented Patient #2 was transferred to a hospital for care related to infection and separation of her back incision.</p> <p>A Resumption of Care assessment, dated 7/20/13, noted Patient #2 was non-compliant with taking her diabetic medications, as well as, following a diabetic diet regimen.</p> <p>The POC for the certification period 7/10/13 to 9/07/13 did not include nursing interventions which addressed the dietary and medication non-compliance.</p> <p>During an interview on 12/19/13 beginning at 10:00 AM, the RN reviewed Patient #2's medical record and confirmed she had not included non-compliance in the POC.</p> <p>The POC did not include all equipment or interventions related to Patient #2's non-compliance with her diabetic medication and diet.</p> <p>9. Patient #5 was a 48 year old female admitted to the agency on 9/10/13 for SN services related to CHF, lymphedema, morbid obesity, HTN, depression, and for blood work studies as ordered related to long term anti-coagulant use.</p> <p>The RN noted on the recertification assessment dated 11/05/13, that Patient #5 was bed bound, had a foley catheter, and was having heavy vaginal bleeding that started 10/31/13.</p> <p>The POC for Patient #5 for the certification period of 11/09/13 through 1/07/14, did not include</p>	G 159	

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G 159	<p>Continued From page 45</p> <p>nursing interventions related to lymphedema such as mobility, exercises, ROM, massage, or compression stockings. Further, the POC did not address interventions related to the prolonged vaginal bleeding Patient #5 experienced. The POC did not address Patient #5's inability to change positions and the risk for impaired skin integrity.</p> <p>During an interview on 12/19/13 beginning at 2:00 PM, the DCS reviewed Patient #5's record and confirmed the POC did not include nursing interventions targeted at symptom management for the lymphedema. She stated she felt as if Patient #5 has given up and no longer able to cope with her disease. The DCS stated she was aware of her prolonged vaginal bleeding and confirmed no labwork had been obtained to determine if she was anemic, although it was discussed with Patient #5 to increase her protein intake and take a multivitamin.</p> <p>The POC did not include nursing interventions related to Patient #5's depression, symptom management of her lymphedema, or activity intolerance.</p>	G 159		
G 160	<p>484.18(a) PLAN OF CARE</p> <p>If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan.</p> <p>This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure physicians were consulted in order to</p>	G 160	<p>G 160</p> <p>MultiCare will ensure that the PCP is notified and a verbal order is received prior to making visits for any service that is ordered on the Plan of Care while awaiting the signed Plan of Care to return to the agency. The case manager will initiate a start of care (recertification/resumption of care if</p>	

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G 160	<p>Continued From page 46</p> <p>authorize additional orders after initial assessments were completed for 5 of 14 patients (#3, #6, #11, #12 and #13) whose records were reviewed. This resulted in the provision of care without physician approval. Findings include:</p> <p>1. Patient #3's medical record documented an 80 year old female who was admitted to the agency on 7/10/13 and died on 8/29/13. Her diagnoses included diabetes, neuropathy, chronic pain, and polypharmacy.</p> <p>A form from a local hospital, titled "Ambulatory referral to Home Health" and dated 7/09/13, stated "Medication management, eval for PT for strengthening."</p> <p>An agency order, dated 7/10/13 but not timed, stated "SN: to evaluate this Patient for services, admit to care, set up POC. PT: evaluate and treat." Another order, dated 7/17/13 at 4:54 PM, called for SN visits 1-2 times a week for 9 weeks and PT visits 1 time the first week, 3 times the second week, and 2 times a week for 2 weeks. The order stated it was retroactive to 7/10/13. The order was signed by the physician on 7/23/13. The order did not indicate it was a verbal order.</p> <p>A nursing evaluation visit for Patient #3 was documented on 7/10/13 at 5:45 PM. Another nursing visit was documented on 7/17/13 from 3:30 PM to 4:30 PM. A PT evaluation visit was documented on 7/11/13. Other PT visits were documented on 7/16/13 and 7/19/13.</p> <p>The DCS reviewed Patient #3's medical record. She stated the order, dated 7/17/13, was a verbal order although she stated this was not</p>	G 160	<p>indicated) order on the SOC (RC/ROC if indicated) date, and will call the PCP to receive verbal orders for the care that is too be provided to the Patient. The case manager will include this verbal order on her start of care order, including who gave the order, and that visits have been approved from the start of care date until the signed Plan of Care has been returned to the agency. The director of Clinical Services will be responsible for orienting the RN and/or PT case managers, and monitoring records to make sure this is taking place. This will be completed 1/21/14.</p> <p>See Addendum #8 and #11</p>	
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G 160	<p>Continued From page 47</p> <p>documented. She confirmed the nursing visit on 7/17/13 and the PT visits on 7/16/13 and 7/19/13 were conducted without documented orders prior to the visits.</p> <p>The physician did not approve orders for nursing and PT visits until after they had been conducted.</p> <p>2. Patient #12's medical record documented a 21 year old female who was admitted to the agency on 10/21/13 and was discharged on 12/18/13. Her diagnoses included a kidney transplant on 9/14/13, non-healing surgical wound, depression, and newly diagnosed diabetes.</p> <p>An untimed order, dated 10/21/13, stated "SN: to evaluate Patient for services, admit to care, set up POC." The order did not indicate it was a verbal order. It was signed by the physician on 11/25/13. Patient #12's POC for the certification period 10/21/13-12/19/13, which called for nursing visits 3 times a week for 9 weeks, was also signed by the physician on 11/25/13.</p> <p>Nursing visits to Patient #12 were documented on 10/23/13, 10/25/13, 10/28/13, 10/30/13, 11/01/13, 11/04/13, 11/06/13, 11/08/13, 11/11/13, 11/13/13, 11/15/13, 11/18/13, and 11/22/13.</p> <p>Patient #12's CM was interviewed on 12/19/13 beginning at 8:40 PM. She confirmed the nursing visits conducted without documented orders prior to the visits.</p> <p>The physician did not approve orders for nursing visits until after they had been conducted.</p> <p>3. Patient #11 was a 70 year old female, admitted to the agency on 10/21/13 for care related to DM</p>	G 160		

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G 160	<p>Continued From page 48</p> <p>II, neuropathy , HTN, A-Fib, and morbid obesity. A comprehensive assessment was completed on 10/21/13 and the POC was implemented. The POC was signed by the physician on 11/06/13.</p> <p>A form titled "DOCTORS ORDERS," noted "Requesting a start of care order for home health services for period 10/21/13-12/19/13." The form noted services would be provided by SN, PT, OT, MSW, and CNA (Home Health Aide), but did not indicate frequency of visits. The form was signed by the physician 11/06/13.</p> <p>Patient #11's record did not indicate the physician had been contacted for verbal orders after the comprehensive assessment had been performed.</p> <p>Patient #11 received SN visits on 10/30/13 and 11/05/13 without a physician's order.</p> <p>Patient #11 received a physical therapy visit on 10/28/13 without a physician's order.</p> <p>Patient #11 received home health aide visits on 10/25/13, 10/31/13, 11/01/13, and 11/05/13 without a physician's order.</p> <p>During an interview on 12/19/13 beginning at 10:00 AM, the CM reviewed Patient #11's record and stated she had not received verbal orders from the physician after performing the comprehensive assessment. She stated she did not routinely obtain verbal orders, that she would write out a written request for physician orders and the POC which would be faxed to the physician. The CM confirmed the home health aide visits, PT, and SN visits that occurred before 11/06/13 were performed without a physician order.</p>	G 160		

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G 160	<p>Continued From page 49</p> <p>The agency provided nursing, HHA, and therapy services before obtaining physician orders.</p> <p>4. Patient #13's medical record documented a 76 year old male admitted to the agency on 10/28/13 with diagnoses including shoulder dislocation after a fall, HTN, and dysmetabolic syndrome. His medical record for the certification period of 10/28/13 through 12/26/13 was reviewed.</p> <p>A "DOCTORS ORDERS" form, dated 10/28/13, documented an order request to initiate home health services. The order request included SN to evaluate Patient #13 for services, admit him to care, and develop a POC. The order request also included PT, OT, and MSW services to evaluate and treat Patient #13, as well as an HHA to assist with bathing and ADL care. There was no documentation on the order request to indicate a verbal order had been received from the physician. The request was signed by the physician on 11/14/13, initiating the order for the services listed above.</p> <p>On 11/12/13, an order request was generated defining the frequencies and treatments for services, including:</p> <ul style="list-style-type: none"> <li>- SN 1-2 times a week for nine weeks.</li> <li>- PT twice a week for six weeks.</li> <li>- OT twice a week for one week, and 1-2 times a week for 2-4 weeks.</li> <li>- MSW twice a month for one month.</li> </ul> <p>The request stated the effective date for these services was 11/04/13. However, there was no documentation to indicate a verbal order was received on 11/04/13 to order the frequencies</p>	G 160		

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G 160	<p>Continued From page 50</p> <p>listed above. It was unclear why the order request was generated 8 days after the effective date. The physician signed the request on 11/14/13, generating the actual order on 11/14/13.</p> <p>Patient #13's medical record documented he received 5 PT visits, on 10/29/13, 10/31/13, 11/05/13, 11/07/13, and 11/12/13, prior to the physician signing the order request. The medical record also documented Patient #13 received 2 OT visits, on 11/04/13 and 11/06/13; 2 RN visits, on 11/04/13 and 11/08/13; and 2 HHA visits, on 11/05/13 and 11/12/13, and 1 MSW visit on 11/06/13, prior to the physician signing the order on 11/14/13.</p> <p>The DCS reviewed the record and was interviewed on 12/18/13 at 2:00 PM. She confirmed there was no documentation to indicate a verbal order had been received prior to the initiation of the services listed above. She confirmed that due to the lack of documentation of a verbal order, RN, PT, OT, MSW, and HHA visits were provided without an order prior to 11/14/13.</p> <p>RN, PT, OT, MSW, and HHA visits were provided without an order.</p> <p>5. Patient #6's medical record documented an 89 year old female admitted to the agency on 9/18/13 with diagnoses of COPD, CHF, and anemia. Her medical record for the certification period of 11/17/13 through 1/15/14 was reviewed.</p> <p>A "DOCTORS ORDERS" form, dated 11/15/13, contained an order request to re-certify Patient #6 for SN 2-3 times a week for 9 weeks for assessment of respiratory status, compliance</p>	G 160			

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G 160	Continued From page 51 with O2 therapy, assessment of bleeding, and lab draws per physician order. There was no documentation to indicate a verbal order had been received for the re-certification. Patient #6 received 4 SN visits, on 11/18/13, 11/20/13, 11/22/13, and 11/25/13, prior to the physician signing the order request on 11/26/13.  The DCS reviewed the record and was interviewed on 12/18/13 at 1:35 PM. She confirmed there was no documentation to indicate a verbal order had been obtained to re-certify Patient #6. She confirmed that 4 SN visits had been provided without an order, prior to the signed order on 11/26/13.	G 160		
G 164	SN visits were provided without an order. 484.18(b) PERIODIC REVIEW OF PLAN OF CARE  Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.  This STANDARD is not met as evidenced by: Based on staff interview and review of policies and records, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the plan of care for 7 of 14 patients (#1, #4, #8, #9, #11, #12, and #13) whose records were reviewed. This resulted in missed opportunity for the physician to alter the POC to meet patient needs. Findings include:  The policy "PATIENT PROBLEMS, ABNORMALITIES, CHANGES IN CONDITION,	G 164	G 164  MultiCare will ensure that staff is promptly alerting the PCP to any changes that suggest a need to change the Plan of Care. The Director of Clinical services will orient the RN/PT case managers, LPN's, Therapists, and any other skilled services involved in a Patient's care, regarding promptly alerting the PCP to any changes that may occur during the certification period, and that may require altering the Patient's Plan of Care (i.e.: elevated blood pressure, constipation, medication changes,	

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G 164	<p>Continued From page 52</p> <p>APPROPRIATE ACTIONS AND DOCUMENTATION," dated 2/12/02, stated "All deviations from normal signs or symptoms, changes from usual patient parameters, or unexpected responses to care, medications, or treatments, and results of relevant laboratory tests or caregiver support or environment, will be thoroughly documented and promptly reported to the patient's physician for guidance as to any needed changes in care...." The agency failed to adhere to its policy as follows:</p> <p>1. Patient #4's medical record documented an 87 year old female admitted to the agency on 2/27/13 with diagnoses including A-fib, HTN, CVA, dementia and history of recent falls. Her medical record for the certification period of 2/27/13 through 4/27/13 was reviewed.</p> <p>An LPN visit note, dated 4/02/13, documented Patient #4 had a sore to her right middle toe. The LPN documented Patient #4 stated her middle toe was very painful when touched. The LPN documented the right middle toe had a sore with a scab on it and the toe was red and swollen. The LPN visit note on 4/02/13 documented she notified the CM. There was no documentation to indicate Patient #4's physician had been notified of the wound.</p> <p>An RN visit note, dated 4/04/13, documented the RN assessed the wound on Patient #4's toe. The RN documented that when she removed the Band-Aid that was covering the wound, the top layer of the scab came off with the Band-Aid, leaving a "crater with yellow slough in the wound bed in the very center? Possible bone as it is right over the first joint, with beefy red tissue surrounding the slough." The RN documented</p>	G 164	<p>falls, changes in medical condition of Patient, Changes in mental status of Patient, unsafe living environment). The Director of Clinical Services and the case manager of the Patient will ensure that the Patient's needs are being met, documented, and communicated appropriately with a call to the PCP, verbal/written orders if indicated, and updates sent to the PCP. The update will be sent promptly to the PCP reflecting detailed changes in the Patient status, and any changes that occur will be discussed during case conferences, documented on the shared communication note on Patient's chart as they occur. The LPN to call the RN case manager during a Patient visit if any change in the Patient's status occurs, and then the RN case manager to advise the LPN on how to proceed. The communication notes to be reviewed daily per the RN case manager to ensure continuity of care. The Director of Nursing to check charts weekly using a checklist to ensure adequate documentation and orders are in place. This will be completed by 1/21/14.</p>	

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G 164	<p>Continued From page 53</p> <p>the wound was 0.7 cm in diameter. The RN also documented she would obtain an order for wound care. However, there was no documentation to indicate the physician was notified of the wound, or a wound care order was received.</p> <p>An LPN visit note, dated 4/08/13, documented she removed a dressing to Paten #4's right middle toe and noted a small amount of serosanguinous exudate on the dressing. The LPN noted the wound had formed a small crater in the interior of the wound. The LPN documented that after "spraying [the wound] with MicroKlense, It did start to bleed. I washed it out with sterile saline and put in powder/gel and placed a foam dressing on top and used hyperfix tape to hold the dressing in place. I then checked her skin and discovered that she had small developing ulcer on her left buttocks area. I sprayed it with hyperfix and placed a foam dressing over with hyperfix tape." There was no documentation to indicate Patient #4's physician was notified of the new ulcer to Patient #4's buttocks, or orders for the wound care noted above were received. In addition, there was still no documentation to indicate the physician was notified of the wound to Patient #4's toe, nor was there documentation of orders provide wound care.</p> <p>An RN visit, dated 4/16/13, documented the RN performed wound care to the wound to Patient #4's toe using "skin prep and apply multidex powder to the wound bed, apply copa foam secure with hypofix tape..." The RN also documented she cleansed and redressed the pressure ulcer to Patient #4's buttocks. The RN then documented Patient #4's "Third toe at the base of the nail remains blackened." It was</p>	G 164	See Addendum #8, #11 and #13		

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G 164	<p>Continued From page 54</p> <p>unclear if this was a new development to the existing wound to Patient #4's right middle toe, or if it was a new development to her left middle toe. There was no documentation to indicate the physician was notified of the blackness to the nail bed.</p> <p>An RN visit note, dated 4/18/13, documented the third toe had a black area at the cuticle. Again, there was no documentation to indicate whether it was the third toe on the right foot or the left foot. There was no documentation to indicate Patient #4's physician was notified of the blackened area to her toe.</p> <p>The DCS reviewed the record and was interviewed on 4/18/13 beginning at 2:00 PM. She confirmed there was no documentation to indicate Patient #4's physician had been notified of the blackened area to her middle toe. She also confirmed that there was no documentation to indicate Patient #4's physician had been notified of the wound to her toe until the order request had been generated on 4/17/13. In addition, she confirmed there was no documentation to indicate the physician was notified of the stage II pressure ulcer to Patient #4's buttock until five days later, when the order request was generated.</p> <p>Patient #4's physician was not notified of changes in her condition.</p> <p>2. Patient #13's medical record documented a 76 year old male admitted to the agency on 10/28/13 with diagnoses including shoulder dislocation after a fall, HTN, and dysmetabolic syndrome. His medical record for the certification period of 10/28/13 through 12/26/13 was</p>	G 164		
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G 164	<p>Continued From page 55 reviewed.</p> <p>The POC, signed by the physician but not dated, included a goal that Patient #13's BP would be less than 160/90. There was no documentation on the POC to indicate BP parameters for which to notify the physician. According the American Heart Association, a normal blood pressure is less than 120 over less than 80.</p> <p>On 11/04/13, the CM documented Patient #13's BP was 158/92. There was no documentation to indicate Patient #13's physician had been notified of this BP.</p> <p>The CM reviewed the record and was interviewed on 12/19/13 at 8:10 AM. She stated she considered anything above 160/90 to be the parameters to call the physician, though she confirmed there was no documentation on the POC specifically stating this. She confirmed she did not call the physician about the BP reading taken 11/04/13, despite the diastolic pressure of 92 exceeding the "parameter" of 90. She then stated that 160/90 was just a goal and not necessarily parameters for when to call the physician.</p> <p>Patient #13's physician was not notified of his elevated BP.</p> <p>3. Patient #8's medical record documented a 70 year old female admitted to the agency on 10/04/13 with diagnoses including lumbar sprain, back pain, and emphysema. Her medical record for the certification periods of 10/04/13 through 12/02/13 and 12/03/13 through 1/31/14 were reviewed.</p>	G 164			

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G 164	<p>Continued From page 56</p> <p>An LPN visit note, dated 11/07/13, documented Patient #8 had not had a BM in 6 days and "had gotten MOM to take although it was unopened. I went ahead and administered 30 mg to her while I was there...." There was no documentation to indicate Patient #8's physician had been notified of her constipation or that she was taking MOM to treat it.</p> <p>An LPN visit note, dated 11/14/13, documented Patient #8 continued to experience constipation and had taken magnesium citrate in addition to the MOM. There was no documentation to indicate Patient #8's physician had been notified of, and approved, the additional medications.</p> <p>An LPN visit note, dated 11/27/13, documented Patient #8 continued to experience constipation and had not had a BM in 4 days. She documented Patient #8 was taking Ex-Lax in addition to the MOM and magnesium citrate. The LPN documented Patient #8 would be seeing her physician on 12/03/13 to update him on her condition. There was no documentation to indicate Patient #8's physician was informed of her frequent constipation or of Patient #8's use of multiple laxatives.</p> <p>The DCS reviewed the record and was interviewed on 12/18/13 at 2:00 PM. She confirmed there was no documentation to indicate Patient #8's physician had been notified of her constipation or of the use of multiple laxatives.</p> <p>Patient #8's physician was not notified of changes in her condition.</p> <p>4. Patient #9's medical record documented a 75</p>	G 164		

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G 164	<p>Continued From page 57</p> <p>year old female admitted to the agency on 4/05/13 with diagnoses including chronic bronchitis, CHF, CAD, and HTN. Her medical record for the certification period of 4/05/13 through 6/03/13 was reviewed.</p> <p>A "PHYSICAL THERAPY EVALUATION," documented by the Physical Therapist on 4/19/13, stated that Patient #9 had fallen during the evaluation visit. The note stated Patient #9 "was standing in living room demonstrating to me how she can't stand or walk without her walker and she started to teeter and fell onto her [left] side and was uninjured. She states the last time she fell was one year ago." There was no documentation to indicate Patient #9's physician had been notified of the fall.</p> <p>The DCS reviewed the record and was interviewed on 12/18/13 at 1:15 PM. She stated it was the agency's practice to notify the physician for falls that are witnessed by agency staff. The DCS confirmed there was no documentation the physician had been notified of Patient #9's fall.</p> <p>Patient #9's physician was not notified of her fall.</p> <p>5. Patient #11 was a 70 year old female, admitted to the agency on 10/21/13 for care related to DM II, neuropathy, HTN, A-Fib, and morbid obesity. A comprehensive assessment was completed on 10/21/13 and the POC for the certification period 10/21/13 to 12/19/13 was implemented. The POC was signed by the physician on 11/06/13.</p> <p>Patient #11 was an insulin dependent diabetic, and the comprehensive assessment noted she had neuropathy of both feet. The National</p>	G 164			

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G 164	<p>Continued From page 58</p> <p>Institute of Health, (June 2012) defined diabetic neuropathy as damage or diseases of nerves of the peripheral nervous system caused by diabetes. Neuropathy may result in pain, tingling, or loss of feeling in the hands, arms, feet, and legs.</p> <p>A nursing visit note dated 11/11/13 from 3:30 PM to 4:30 PM, described Patient #11 as having pain and swelling in her right great toe. The toe was noted to be red to the second joint and warm to the touch. The RN noted she was able to express infectious material from under the toenail. She documented Patient #11's foot was soaked in a warm salt bath and then she trimmed her toenails. The RN noted she instructed Patient #11 to soak her feet in warm salt water several times a day until further instructed by the physician. The wound on Patient #11's left thigh was documented as "...now progressed to an unstageable ulcer, covered with yellow slough." The nursing note did not document physician notification regarding the progression of Patient #11's thigh wound, the infection under her right toenail, or to receive orders for the warm salt baths and foot care. There was no documentation Patient #11's physician had been notified.</p> <p>In a nursing visit note dated 11/19/13 from 2:15 PM to 4:00 PM, the RN documented Patient #11 was on antibiotics for the infection in the left thigh wound. She wrote "I look at her great left toe today and I have to think now about Gout the toe is swollen and red to below the tarsal-metatarsal joint." The nursing visit note described the left great toe, however, the previous visit note dated 11/11/13 described her right great toe. The skilled intervention section of the nursing visit</p>	G 164			

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G 164	<p>Continued From page 59</p> <p>note noted Patient #11 was instructed in wound care, infections and gout. The nursing visit note did not document physician notification regarding the appearance of the toe.</p> <p>In a nursing visit note dated 11/25/13 from 3:15 PM to 4:30 PM, Patient #11's left great toe was noted to be more swollen than the previous visit, magenta in color, and hot to the touch. The RN noted it was painful to palpation. The skilled intervention section of the nursing visit note documented Patient #11 was instructed to make an appointment to see the podiatrist as her toe was not getting better. The nursing visit note did not document she had contacted the physician regarding the painful, swollen, and discolored toe.</p> <p>A nursing visit note dated 11/29/13 from 3:15 PM to 4:45 PM, the RN documented Patient #11's "great right toe is still very red purple in color and it is painful." The previous two visits described Patient #11's left great toe. There was no documentation Patient #11 had been assisted to make an appointment with the podiatrist, or of notification of her physician regarding the condition of her inflamed toe.</p> <p>A nursing visit note dated 12/09/13 from 12:45 PM to 2:30 PM, the RN documented Patient #11's "toe is much less red, however her second toe is red with a hard white spot on top of the joint." The note did not describe whether it was the right foot or the left foot. There was no documentation of physician notification regarding the additional area of concern on the second toe.</p> <p>A nursing visit note dated 12/10/13 from 12:45 PM to 2:30 PM, the RN documented Patient #11 had been seen by the podiatrist and started on</p>	G 164			

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G 164	<p>Continued From page 60</p> <p>antibiotics for her right great toe. The record did not indicate the attending physician who was listed on the POC was notified of an additional care provider making medication and treatment decisions for Patient #11.</p> <p>During an interview on 12/19/13 beginning at 10:00 AM, the RN reviewed Patient #11's record and confirmed the above documentation. She stated she had instructed Patient #11 to make an appointment with a podiatrist. The RN stated she was not consistent with notification of the physician regarding the changing status of Patient #11's wounds.</p> <p>Patient #11's physician was not notified of her changing medical condition that suggested a need to alter her her POC.</p> <p>6. Patient #1's medical record documented an 85 year old female who was admitted to the agency on 7/15/13 and was discharged on 10/29/13. The record stated she was admitted to a skilled nursing facility on 10/07/13. She did not return home after admission. Her diagnoses included fractured lumbar vertebra, osteoporosis, and diabetes.</p> <p>A "PHYSICAL THERAPY EVALUATION," dated 7/16/13 at 4:15 PM, stated Patient #1 was admitted after a compression fracture of her back after a fall. The evaluation stated Patient #1 lived alone and her daughter lived across the street. The evaluation stated she was a "...very high fall risk...and at this time is unable to safely care for herself in her home."</p> <p>A "COMMUNICATION NOTE" by the DCS, dated 7/23/13 at 4:24 PM, stated Patient #1 fell and was</p>	G 164		

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G 164	<p>Continued From page 61</p> <p>taken to a local emergency department after the fall. She was not admitted. The note stated she was diagnosed with a closed left hip fracture. The note stated there was nothing to be done except pain management. Documentation was not present in Patient #1's record that her the physician was notified of this fall.</p> <p>A "PHYSICAL THERAPY VISIT NOTE," dated 8/12/13 at 3:00 PM, stated Patient #1 was not safe with many of the activities she does in her home. A "PHYSICAL THERAPY VISIT NOTE," dated 8/19/13 at 3:00 PM, stated "It is a concern that I have found pt on the toilet twice now unable to get her pants on. Spoke to pt about being alone and how unsafe it is for her." Documentation was not present in Patient #1's record that the physician was notified of her unsafe status.</p> <p>A "COMMUNICATION NOTE" by the LPN, dated 8/27/13 at 5:08 PM, stated Patient #1 was found on the floor when the LPN made a home visit. The note said Patient #1 stated she had been on the floor for about 30 minutes. Documentation was not present in Patient #1's record that her physician was notified of this fall.</p> <p>The DCS was interviewed on 12/19/13 beginning at 9:25 AM. She stated Patient #1 was admitted to home health services after a fall which fractured a vertebra. She stated Patient #1's daughter lived across the street but said the daughter worked full time. She stated Patient #1 needed 24 hour supervision. She stated Patient #1's posture was very hunched over and she had an extremely unsteady gait. She confirmed Patient #1's physician had not been notified of the falls or of the patient's unsafe living situation.</p>	G 164			

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G 164	<p>Continued From page 62</p> <p>Patient #1's physician was not notified of falls and was not alerted to her unsafe living situation.</p> <p>7. Patient #12's medical record documented a 21 year old female who was admitted to the agency on 10/21/13 and was discharged on 12/18/13. Her diagnoses included a kidney transplant on 9/14/13, non-healing surgical wound, depression, and newly diagnosed diabetes.</p> <p>A laboratory report from Patient #12's local hospital, dated 5/04/13, stated normal blood sugar levels were between 74 and 106. Very high blood sugar levels can lead to a condition called diabetic ketoacidosis. According to the American Diabetes Association website, queried on 12/23/13, diabetic ketoacidosis is a serious condition that can lead to diabetic coma or even death.</p> <p>A "SKILLED NURSE VISIT NOTE," dated 11/27/13 at 11:30 AM, stated the nurse reviewed Patient #12's blood sugar log and 1 reading was over 600. (600 is the maximum reading on most home glucometers). A "SKILLED NURSE VISIT NOTE," dated 8/12/13 at 3:00 PM, stated several blood sugar readings were over 600. "SKILLED NURSE VISIT NOTE[s]," dated 11/11/13, 10/30/13, 10/28/13, 10/25/13, and 10/23/13, all stated Patient #12's blood sugar log readings were over 500. No documentation was present for any of these notes that the physician was notified of the elevated blood sugar levels.</p> <p>Patient #12's medical record documented she lived with her parents. A "SKILLED NURSE VISIT NOTE," dated 12/09/13 at 4:00 PM, stated Patient #12 had a lot of stress at home. The note</p>	G 164			

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G 164	Continued From page 63 stated the police had left just prior to the nursing visit after responding to a fight between Patient #12 and her mother. No documentation was present the physician was notified of the incident.  Patient #12's RN was interviewed on 12/19/13 beginning at 8:40 AM. She reviewed the record and confirmed the physician was not notified of the above incidents.	G 164			
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE  The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.  This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure physicians were informed of changes in condition for 3 of 14 patients (#1, #11, and #12) whose records were reviewed. This prevented physicians from changing POCs to meet patient needs. Findings include:  1. Patient #11 was a 70 year old female, admitted to the agency on 10/21/13 for care related to DM II, neuropathy, HTN, A-Fib, and morbid obesity. A comprehensive assessment was completed on 10/21/13 and the POC for the certification period 10/21/13 to 12/19/13 was implemented. The POC was signed by the physician on 11/06/13.	G 176	G 176  MultiCare will ensure that the RN is informing the PCP of changes in the Patient's condition to allow for the PCP to make changes to the Patient's Plan of Care to meet the Patient's needs. The Director of Clinical Services will orient the RN's on staff to call the PCP for changes in a Patient's condition that will affect the care that is being delivered to the Patient. The RN will call the PCP promptly to report changes, and receive a verbal order for anything that will require making a change to the Patient's Plan of Care (i.e.: s/sx infection, compromised safety of Patient, falls). The RN will send over orders to the PCP, to which a verbal order has been received for,		

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G 176	Continued From page 64  Patient #11 was an insulin dependent diabetic, and noted to have neuropathy of both feet.  - A nursing visit note dated 11/11/13 from 3:30 to 4:30 PM, described Patient #11 as having pain and swelling in her right great toe. The toe was noted to be red to the second joint and warm to the touch. The RN noted she was able to express infectious material from under the toenail. She documented Patient #11's foot was soaked in a warm salt bath and then she trimmed her toenails. The RN noted she instructed Patient #11 to soak her feet in warm salt water several times a day until further instructed by the physician. The wound on Patient #11's left thigh was documented as "...now progressed to an unstageable ulcer, covered with yellow slough." The nursing note did not document physician notification regarding the progression of Patient #11's thigh wound, the infection under her right toenail, or to receive orders for the warm salt baths and foot care.  - A nursing visit note dated 11/19/13 from 2:15 PM to 4:00 PM, the RN documented Patient #11 was on antibiotics for the infection in the left thigh wound. She wrote "I look at her great left toe today and I have to think now about Gout the toe is swollen and red to below the tarsal-metatarsal joint." The nursing visit note described the left great toe, however, the previous visit note dated 11/11/13 described her right great toe. The skilled intervention section of the nursing visit note noted Patient #11 was instructed in wound care, infections and gout. The nursing visit note did not document physician notification regarding the appearance of the toe.	G 176	and communicate with other services involved in providing care for the Patient. The RN will document changes in the Patient's condition as they occur on the shared communication note in the Patient's Chart as well as in the visit note. The Director of Clinical Services will check charts weekly using a checklist to ensure the RN is adequately informing the PCP and communicating with others involved with the Patient's care. This will be completed by 1/21/14.		

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G 176	<p>Continued From page 65</p> <p>- A nursing visit note dated 11/22/13 from 12:00 PM to 1:30 PM, the RN documented Patient #11's left great toe was warmer than the previous visit, although it appeared less swollen. She stated it was more of a magenta color.</p> <p>- A nursing visit note dated 11/25/13 from 3:15 PM to 4:30 PM, Patient #11's left great toe was noted to be more swollen than the previous visit, magenta in color, and hot to the touch. The RN noted it was painful to palpation. The skilled intervention section of the nursing visit note documented Patient #11 was instructed to make an appointment to see the podiatrist as her toe was not getting better. The nursing visit note did not document she had contacted the physician regarding the painful, swollen, and discolored toe.</p> <p>- A nursing visit note dated 11/29/13 from 3:15 PM to 4:45 PM, the RN documented Patient #11's "great right toe is still very red purple in color and it is painful." The previous two visits described Patient #11's left great toe. There was no documentation Patient #11 had been assisted to make an appointment with the podiatrist, or of notification of her physician regarding the condition of her inflamed toe.</p> <p>- A nursing visit note dated 12/09/13 from 12:45 PM to 2:30 PM, the RN documented Patient #11's "toe is much less red, however her second toe is red with a hard white spot on top of the joint." The note did not describe whether it was the right foot or the left foot. There was no documentation of physician notification regarding the additional area of concern on the second toe.</p> <p>- A nursing visit note dated 12/10/13 from 12:45 PM to 2:30 PM, the RN documented Patient #11</p>	G 176		

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G 176	<p>Continued From page 66</p> <p>had been seen by the podiatrist, and been started on antibiotics for her right great toe. The record did not indicate the attending physician who was listed on the POC was notified of an additional care provider who had implemented medication and treatment decisions for Patient #11.</p> <p>During an interview on 12/19/13 beginning at 10:00 AM, the RN reviewed Patient #11's record and stated she had instructed Patient #11 to make an appointment with a podiatrist. She was unable to determine if the ordering physician on the POC was aware of that referral. The RN stated she was not consistent with notification of the physician regarding the changing status of Patient #11's wounds.</p> <p>Patient #11's care was not coordinated to include notification of her primary physician regarding her changing medical needs.</p> <p>2. Patient #12's medical record documented a 21 year old female who was admitted to the agency on 10/21/13 and was discharged on 12/18/13. Her diagnoses included a kidney transplant on 9/14/13, non-healing surgical wound, depression, and newly diagnosed diabetes.</p> <p>A "SKILLED NURSE VISIT NOTE," dated 11/27/13 at 11:30 AM, stated the nurse reviewed Patient #12's blood sugar log and 1 reading was over 600. "SKILLED NURSE VISIT NOTE[s]," dated 11/11/13, 10/30/13, 10/28/13, 10/25/13, and 10/23/13, all stated Patient #12's blood sugar log readings were over 500. No documentation was present in any of the notes that the physician was notified of the elevated blood sugar levels.</p> <p>Patient #12's medical record documented she</p>	G 176		

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G 176	<p>Continued From page 67</p> <p>lived with her parents. A "SKILLED NURSE VISIT NOTE," dated 12/09/13 at 4:00 PM, stated Patient #12 had a lot of stress at home. The note stated the police had left just prior to the nursing visit after responding to a fight between Patient #12 and her mother. No documentation was present the physician was notified of the incident.</p> <p>Patient #12's RN was interviewed on 12/19/13 beginning at 8:40 AM. She reviewed the record and confirmed the nurse did not notify the physician of the above incidents.</p> <p>Patient #12's physician was not informed of changes in her condition by the nurse.</p> <p>3. Patient #1's medical record documented an 85 year old female who was admitted to the agency on 7/15/13 and was discharged on 10/29/13. The record stated she was admitted to a skilled nursing facility on 10/07/13. She did not return home after admission. Her diagnoses included fractured lumbar vertebra, osteoporosis, and diabetes.</p> <p>A "COMMUNICATION NOTE" by the DCS, dated 7/23/13 at 4:24 PM, stated Patient #1 fell and was taken to a local emergency department after the fall. The note stated she was diagnosed with a closed left hip fracture. The note stated there was nothing to be done except pain management. Documentation was not present in Patient #1's record that her physician was notified of this fall.</p> <p>A "SKILLED NURSE VISIT NOTE," dated 8/27/13 at 5:08 PM, stated Patient #1 was found on the floor during a home visit. The note said Patient</p>	G 176			

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G 176	Continued From page 68 #1 stated she had been on the floor for about 30 minutes. Documentation was not present in Patient #1's record that her physician was notified of this fall.  The DCS was interviewed on 12/19/13 beginning at 9:25 AM. She confirmed Patient #1's physician had not been notified of the falls.	G 176		
G 215	Patient #1's physician was not notified of falls. 484.36(b)(2)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAI  The home health aide must receive at least 12 hours of in-service training during each 12 month period. The in-service training may be furnished while the aide is furnishing care to the patient.  This STANDARD is not met as evidenced by: Based on review of policies, staff interview, and review of personnel files, it was determined the agency failed to ensure 12 hours of in-service training were provided to the 1 of 1 HHA employed by the agency whose personnel file was reviewed. This failure resulted in care being provided by potentially unqualified personnel. Findings include:  The policy "HOME HEALTH AIDE TRAINING," dated 2/12/02, stated "Each aide must complete at least twelve hours of in-service per calendar year...If the aide is deficient in meeting the required in-service hours at the end of the calendar year, s/he will be terminated."  Personnel files were reviewed with the Human Resources Director on 12/17/13 beginning at 8:25	G 215	G 215  MultiCare will ensure that the Home Health Aide has received at least 12 hours of in-service training during each 12 month period. The administrator and the Director of Clinical Services verified that in-service hours had been completed per the Home Health Aide by the end of the year. The Director of Human Resources will ensure that the Home Health Aide is completing her in-service hours by the end of the year. This has already been completed.  See addendum #14  Completion date 12/23/13	

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G 215	Continued From page 69 AM. The agency employed one HHA, hired 11/13/12, at the time of the survey. The HHA's personnel file documented she had only participated in 9 hours of in-service training from her date of hire. The HR Director confirmed the personnel file documented the HHA had not completed 12 hours of annual in-service training.	G 215		
G 225	The agency did not ensure the HHA received 12 hours of in-service training annually. 484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE  The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law.  This STANDARD is not met as evidenced by: Based on observation, staff interview and review of medical records, it was determined the agency failed to ensure HHAs provided services in accordance with the plan of care for 1 of 1 patient (#7) who received HHA services, that were observed during a home visit. This had the potential to interfere with safety and quality of patient care. Findings include:  1. Patient #7 was a 90 year old male who was admitted to the agency on 6/08/13 for skilled nursing related to wound care, and HHA services for personal care per HHA assignment sheet. The "HOME HEALTH/ HOME CARE- AIDE ASSIGNMENT SHEET" form was completed by the RN on 7/16/13.  During a home visit on 12/18/13 at 7:30 AM, the	G 225	G 225  MultiCare will ensure that the Home Health Aide is providing services in accordance with the Plan of Care to ensure safety and quality care is being provided. The RN case manager will only delegate to the Home Health Aide duties within CNA scope of practice. The Home Health Aide will not be delegated to perform wound care on any Patient. The RN case manager will complete the Home Health Aide assignment sheet when this service has been ordered, and it will reflect duties for the Home Health Aide to perform that will meet this Patient's personal care needs, and keep this Patient safe while duties are being performed. The Director of Clinical Services will be responsible for	

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G 225	<p>Continued From page 70</p> <p>HHA was observed providing wound care to Patient #7's right leg. The HHA removed the gauze and peeled off the Adaptic wound dressing which was directly on the wound bed. She then assisted Patient #7 with a shower. She stated during the shower, she cleansed the wound by applying liquid soap directly to her gloved finger, then rinsed the leg with water. After the shower, the HHA assisted Patient #7 with dressing. She then took a picture on her phone of the leg wound, and sent it to the RN. The HHA placed gauze against the wound, sprayed the gauze with wound cleanser, and applied a netting to secure the gauze. She stated she frequently will provide the same wound care as she comes to Patient #7's home early in the day to bathe him before the nurse is able to come out.</p> <p>The "HOME HEALTH/ HOME CARE- AIDE ASSIGNMENT SHEET" form completed by the RN on 7/16/13, was reviewed. It did not include wound care.</p> <p>In an interview on 12/19/13 at 10:00 AM, the RN stated a HHA could perform dressing changes if delegated to do so by the nurse. She confirmed the HHA had provided wound care for Patient #7, however it was not delegated on the HHA assignment sheet.</p> <p>The HHA performed wound care for Patient #7 that was not included as a delegated function on the assignment sheet.</p>	G 225		
G 235	484.48 CLINICAL RECORDS	G 235	<p>G 235</p> <p>Refer to G 236</p> <p>Completion date 1/21/14</p>	
	This CONDITION is not met as evidenced by:			

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G 235	Continued From page 71 Based on interview and review of clinical records and policies and procedures, it was determined that the HHA failed to ensure clinical records were maintained in accordance with accepted professional standards. This resulted in a record keeping system that did not accurately reflect current comprehensive patient information. The findings include:  Refer to G236 as it relates to the facility's failure to ensure patient records included accurate comprehensive identifying information.  The cumulative effect of this deficient systemic practices resulted in the agency's inability to ensure effective, efficient, and coordinated care.	G 235			
G 236	484.48 CLINICAL RECORDS  A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure medical records were complete and contained past and current findings for 6 of 14 patients (#3, #6, #11, #12, #13, and #14) whose records were reviewed. As a result, complete and current	G 236	G 236  MultiCare will ensure that Patient Clinical Records will contain accurate, comprehensive identifying information to ensure effective, efficient, and coordinated care. The Clinical Record will be maintained for every Patient receiving Home Health Services, and contain (but not limited too) a signed Plan of Care, appropriate identifying information, name of PCP, drug, dietary, treatment, and activity orders, signed and dated clinical and progress notes, copies of summary reports sent to the attending PCP, and a discharge summary. The RN		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137093	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  12/20/2013
NAME OF PROVIDER OR SUPPLIER  MULTICARE HOME HEALTH SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 324 SOUTH MERIDIAN RD, SUITE 10 MERIDIAN, ID 83642		
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G 236	<p>Continued From page 72 information was unavailable to staff provding patient care. Findings include:</p> <p>1. Patient #6's medical record documented an 89 year old female admitted to the agency on 9/18/13 with diagnoses of COPD, CHF, and anemia. Her medical record for the certification period of 11/17/13 through 1/15/14 was reviewed and contained the following incomplete information:</p> <p>a. An LPN visit note, dated 12/04/13, documented Patient #6 had DME including grab bars, a front wheeled walker, a bath bench, and a wheelchair. None of these items were included on the POC. In addition, none of these items were seen in Patient #6's home during an observation of an LPN visit on 12/18/13 at 11:00 AM.</p> <p>The DCS, who was also the CM for Patient #6, reviewed the record and was interviewed on 12/18/13 at 1:25 PM. She stated the visit note was inaccurate, Patient #6 did not have grab bars, a front wheeled walker, bath bench or wheelchair.</p> <p>b. An LPN visit note, dated 12/02/13, documented Patient #6 had weights ranging between 120 and 131 pounds over the weekend prior to the visit. During an observation of an LPN visit to Patient #6's home on 12/18/13 at 11:00 AM, the LPN stated the physician was to be notified of a weight variance of 5 pounds or more. There was no documentation to indicate the physician had been notified of the weight variance. In addition, a log book recording Patient #6's daily weights was reviewed during an observation of an LPN visit on 12/18/13 at 11:00</p>	G 236	<p>case manager will perform a comprehensive assessment at start of care to include (but not limited too) accurate durable medical equipment (DME) in the Patient's home, and then review the Plan of Care with any other discipline that will be providing care to a Patient, and provide a copy of the Plan of Care to other services to use as a guideline while treating a Patient. If new durable medical equipment is obtained through the course of the cert period, then the case manager will write an order to PCP to include this on the Plan of Care for Patient. The case manager will make sure that if a Patient is having Lab work done while open for services, that a copy of the labs are requested and sent to the agency to be reviewed and placed in the Patient's chart. The case manager will not accept a Patient referral if all services ordered (if needed) for this Patient's Plan of Care are not available within 48 hours of admission of this Patient for services, unless it is a Patient related reason for the delay, and/or the Patient has declined this service. The PCP will be promptly notified that the Patient declined a</p>		

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G 236	<p>Continued From page 73</p> <p>AM. There was no documentation in the log book to indicate Patient #6 had weights ranging from 120 to 131.</p> <p>The DCS, who also the CM for Patient #6, reviewed the record and was interviewed on 12/18/13 at 1:25 PM. She stated the LPN had made in error in charting, and had meant Patient #6's weight had ranged from 130 to 131 pounds over the weekend. She stated she had reviewed the log book of Patient #6's weights and she had been consistently 130 to 131 pounds.</p> <p>Patient #6's medical record contained inaccurate information.</p> <p>2. Patient #11 was a 70 year old female, admitted to the agency on 10/21/13 for care related to DM II, neuropathy, HTN, A-Fib, and morbid obesity. A comprehensive assessment was completed on 10/21/13 and the POC was implemented. The POC was signed by the physician on 11/06/13.</p> <p>Patient #11 was an insulin dependent diabetic, and noted to have neuropathy of both feet.</p> <p>A nursing visit note dated 11/11/13 from 3:30 to 4:30 PM, described Patient #11 as having pain and swelling in her right great toe. The toe was noted to be red to the second joint and warm to the touch. The RN noted she was able to express infectious material from under the toenail.</p> <p>A nursing visit note dated 11/19/13 from 2:15 PM to 4:00 PM, the RN documented "I look at her great left toe today and I have to think now about</p>	G 236	<p>service that was ordered, and/or the reason for the delay. There will be clear and concise documentation on the Patient's chart in the shared communication note, and written on the start of care (re-cert/resumption of care if indicated) order to the PCP. The case manager will initiate a start of care (recertification/resumption of care if indicated) order on SOC (RC/ROC if indicated) date, and will call PCP to receive verbal orders for the care that is to be provided to the Patient. The case manager will include this verbal order on her start of care order, including who gave the order, and that visits have been approved from the start of care date until the signed Plan of Care has been returned to the agency. The case manager will review each visit note before sending it in for completion, to ensure documentation is accurate, that it reflects clear and concise assessment data (i.e.: the right body part that is being treated), and that the visit follows the Plan of Care and/or any additional orders regarding a Patient. The case manager will review LPN visit notes for accuracy, and to ensure that</p>		

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G 236	<p>Continued From page 74</p> <p>Gout the toe is swollen and red to below the tarsal-metatarsal joint." The nursing visit note described the left great toe, however, the previous visit note dated 11/11/13 described her right great toe.</p> <p>A nursing visit note dated 11/22/13 from 12:00 PM to 1:30 PM, the RN documented Patient #11's left great toe was warmer than the previous visit, although it appeared less swollen. She stated it was more of a magenta color.</p> <p>A nursing visit note dated 11/25/13 from 3:15 PM to 4:30 PM, Patient #11's left great toe was noted to be more swollen than the previous visit, magenta in color, and hot to the touch. The RN noted it was painful to palpation.</p> <p>A nursing visit note dated 11/29/13 from 3:15 PM to 4:45 PM, the RN documented Patient #11's "great right toe is still very red purple in color and it is painful." The previous two visits described Patient #11's left great toe.</p> <p>A nursing visit note dated 12/05/13 from 10:00 AM to 11:30 AM, the LPN documented Patient #11's left great toe was red and enlarged, and warm to the touch. The previous note, dated 11/29/13 described the right great toe.</p> <p>A nursing visit note dated 12/09/13 from 12:45 PM to 2:30 PM, the RN documented Patient #11's "toe is much less red, however her second toe is red with a hard white spot on top of the joint." The note did not describe whether it was the right foot or the left foot.</p> <p>A nursing visit note dated 12/10/13 from 12:45 PM to 2:30 PM, the RN documented Patient #11</p>	G 236	<p>the visiting nurse is following the Plan of Care and any additional orders for a Patient, and then sign off on the LPN note before it is sent in to the agency for completion. The case manager will be checking charts at least weekly using a chart checklist to ensure frequency and duration are being followed as ordered for each discipline involved in the Patient's care. The case manager to promptly notify PCP if a service is discharging a Patient prior to care planned duration, including a discharge summary, and discharge order (verbal included). The agency has placed an ad to hire a Clinical Care Coordinator. The Director of Clinical Services to be responsible for orienting the case managers regarding clinical record management. The Director of Clinical Services will review the chart checklists with the case managers weekly to ensure chart accuracy, compliance, and that the Patient's needs are being met as the PCP has ordered, following the Plan of Care, and any additional orders throughout the cert period. This will be completed by 1/21/14</p>	

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G 236	<p>Continued From page 75</p> <p>had been seen by the podiatrist, and been started on antibiotics for her right great toe.</p> <p>During an interview on 12/19/13 beginning at 10:00 AM, the RN reviewed Patient #11's record and confirmed the documentation discrepancies regarding the left and the right toe.</p> <p>Documentation was not clear and accurate regarding Patient #11's infected toe.</p> <p>3. Patient #14's medical record documented a 65 year old female who was admitted to home health care on 5/06/13 and was transferred to hospice care on 10/30/13. Her diagnoses included motor neuron disease and COPD.</p> <p>Patient #14's record contained a physician order, dated 5/15/13 at 6:44 PM, for ST one visit every other week. However, an ST evaluation was not documented until 8/13/13. Physician notification of the delay was not present in the record.</p> <p>The DCS was interviewed on 12/19/13 beginning at 10:20 AM. She confirmed the lack of ST services when they were ordered. She stated the therapy company the agency contracted with for ST services did not have ST available when it was ordered. The DCS stated Patient #14's physician had been informed of the lack of ST services and the inability to carry out the orders but she stated this was not documented.</p> <p>The agency failed to document physician notification of delayed services.</p> <p>4. Patient #3's medical record documented an 80 year old female who was admitted to the agency on 7/10/13 and died on 8/29/13. Her diagnoses</p>	G 236	See addendum #8 and #16	

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G 236	<p>Continued From page 76</p> <p>included diabetes, neuropathy, chronic pain, and polypharmacy.</p> <p>An agency order, dated 7/10/13 but not timed, stated "SN: to evaluate this Patient for services, admit to care, set up POC. PT: evaluate and treat." Another order, dated 7/17/13 at 4:54 PM, called for SN visits 1-2 times a week for 9 weeks and PT visits 1 time the first week, 3 times the second week, and 2 times a week for 2 weeks. The order stated it was retroactive to 7/10/13. The order was signed by the physician on 7/23/13. The order did not indicate it was a verbal order.</p> <p>A nursing evaluation visit for Patient #3 was documented on 7/10/13 at 5:45 PM. Another nursing visit was documented on 7/17/13 from 3:30 PM to 4:30 PM. A PT evaluation visit was documented on 7/11/13. Other PT visits were documented on 7/16/13 and 7/19/13.</p> <p>The DCS reviewed Patient #3's medical record. She stated the order, dated 7/17/13, was a verbal order although she stated this was not documented.</p> <p>The agency failed to document verbal orders.</p> <p>5. Patient #12's medical record documented a 21 year old female who was admitted to the agency on 10/21/13 and was discharged on 12/18/13. Her diagnoses included a kidney transplant on 9/14/13, non-healing surgical wound, depression, and newly diagnosed diabetes.</p> <p>Patient #12's POC for the certification period 10/21/13-12/19/13 stated she took 2 immunosuppression medications, Hecoria and</p>	G 236		

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G 236	<p>Continued From page 77</p> <p>Myfortic. These medications require regular laboratory testing to determine how susceptible patients are to infection and whether infection precautions should be implemented. Laboratory test results following her admission were not present in Patient #12's medical record.</p> <p>Patient #12's RN was interviewed on 12/19/13 beginning at 8:40 AM. She stated Patient #12 had undergone weekly laboratory testing since admission to monitor her immunosuppression. The RN stated the laboratory test results were not documented in the medical record.</p> <p>The agency failed to document laboratory test results.</p> <p>6. Patient #13's medical record documented a 76 year old male admitted to the agency on 10/28/13 with diagnoses including shoulder dislocation after a fall, dysmetabolic syndrome, and HTN. His medical record for the certification period of 10/28/13 through 12/26/13 was reviewed. Patient #13's medical record lacked current and complete information as follows:</p> <p>a. The POC, signed by the physician but not dated, documented MSW visits were to be made twice a month for one month to assist Patient #13 with accessing resources to allow him to remain safely in his home.</p> <p>An MSW visit was made to Patient #13's home on 11/06/13. The MSW documented Patient #13 needed assistance with housekeeping and shopping, and assistance with applying for Medicaid, food stamps, emergency assistance and energy assistance. The MSW documented she assisted Patient #13 in completing an</p>	G 236		

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G 236	<p>Continued From page 78</p> <p>application for Medicaid. There was no documentation to indicate assistance with the other needs identified.</p> <p>There were no further MSW visits documented in the medical record at the time of the survey on 12/18/13. There was no documentation by the MSW indicting the status of Patient #13's Medicaid application or any other resources that may be available to him. There was no documentation to indicate the physician had been notified of the MSW's inability to provide 2 visits per month in accordance with the POC.</p> <p>The CM reviewed the record and was interviewed on 12/19/13 at 8:10 AM. She confirmed the MSW had not made 2 visits per month in accordance with the POC. She confirmed there was no documentation from the MSW indicating the status of Patient #13's Medicaid application. She stated Patient #13 had been denied Medicaid. She also stated the MSW "really couldn't do anything for him because he makes too much money" and therefore had not continued to see Patient #13.</p> <p>b. A "COMMUNICATION NOTE," documented by the Occupational Therapist on 11/01/13, stated the Occupational Therapist had called Patient #13 to schedule his OT evaluation, but Patient #13 told her he had been admitted to the hospital earlier in the day and might go home the next day. The Occupational Therapist documented Patient #13 was unsure why he had been admitted.</p> <p>A "PATIENT MISSED VISIT" note, documented by the Occupational Therapist on 11/02/13, stated Patient #13 had been admitted to the hospital on</p>	G 236		

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G 236	<p>Continued From page 79</p> <p>11/01/13 for blood pressure issues but thought he would be home that night.</p> <p>A "COMMUNICATION NOTE," documented by the Occupational Therapist on 11/03/13, stated the Occupational Therapist spoke with Patient #13 on 11/02/13 and he stated he was still at the hospital but thought he would be discharged in the afternoon (on 11/02/13). She documented one of the PTAs had called her to say Patient #13 had been discharged but it was unclear how long he had been in the hospital.</p> <p>An RN visit note, dated 11/04/13, the CM documented "...apparently in the hospital over the weekend." There was no documentation to indicate how long he was in the hospital or for what reason.</p> <p>The CM reviewed the record and was interviewed on 12/19/13 at 8:10 AM. She stated Patient #13 had gone to the ER because of his HTN. She stated he had not been admitted. She confirmed there was no documentation to explain why Patient #13 had gone to the ER, nor was there documentation to indicate Patient #13's physician had been notified he had gone to the ER. She stated this information should have been documented in the "COMMUNICATION NOTE" to ensure all staff caring for Patient #13 were aware of his ER visit.</p> <p>Patient #13's medical record did not include all current and pertinent information related to his POC and current status.</p>	G 236			
G 242	484.52 EVALUATION OF THE AGENCY'S PROGRAM	G 242	<p>G 242</p> <p>Refer to G 244, G 245, G 248, G249,</p>		

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G 242	<p>Continued From page 80</p> <p>This CONDITION is not met as evidenced by: Based on review of agency policies, administrative documentation, meeting minutes, and staff interview, it was determined the agency failed to ensure an evaluation of the its program was conducted. This resulted in the inability of the agency to evaluate patient care services and generate changes to improve the delivery of those services. Findings include:</p> <ol style="list-style-type: none"> <li>1. Refer to G244 as it relates to the agency's failure to ensure an evaluation, including an overall policy review and a clinical record review, had been conducted.</li> <li>2. Refer to G245 as it relates to the agency's failure to ensure an annual evaluation was performed to assess the extent to which the agency's program was appropriate, adequate, effective and efficient.</li> <li>3. Refer to G248 as it relates to the agency's failure to ensure agency policies were reviewed as part of the annual evaluation.</li> <li>4. Refer to G249 as it relates to the agency's failure to ensure mechanisms were established in writing for the collection of data for the evaluation.</li> </ol> <p>3. Refer to G250 as it relates to the agency's failure to ensure health professionals representing the scope of the program as part of the quarterly record review.</p> <p>The cumulative effect of these negative systemic practices seriously impeded the ability of the agency to determine whether the services it</p>	G 242	<p>G 242</p> <p>Refer to G 244, G 245, G 248, G249, G 250, G 244</p> <p>Completion date 1/21/14</p>	

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G 242	Continued From page 81 provided were of adequate quality.	G 242			
G 244	<p>484.52 EVALUATION OF THE AGENCY'S PROGRAM</p> <p>The evaluation consists of an overall policy and administrative review and a clinical record review.</p> <p>This STANDARD is not met as evidenced by: Based on review of quality assurance documentation and staff interview, it was determined the agency failed to ensure an evaluation, including an overall policy review and a clinical record review, had been conducted. This resulted in a lack of information that could be used to evaluate the agency's performance. Findings include:</p> <p>1. The form "ANNUAL EVALUATION OUTLINE," with a hand written date of 2013 in the upper right hand corner, was 11 pages in total. The form was broken into categories of "Organization, Administration, Nursing Services, Therapy Services, Home Healthy [sic], Aide Service, and Coordination." Each item on the form was marked "Yes." There were no comments for any item to indicate whether the item was sufficient or improvement was needed.</p> <p>The DCS was interviewed on 12/31/13 beginning at 9:40 AM. She stated she and the Assistant Administrator completed the "ANNUAL EVALUATION OUTLINE" form about 6 months ago. She stated the evaluation was not complete even though the boxes were all checked. She stated some items were checked Yes in anticipation that they would be completed later. She stated a more comprehensive evaluation had</p>	G 244	<p>G 244</p> <p>1/16/14 MultiCare Home Health conducted its Annual Agency Evaluation at PAC meeting. Clinical record review has been initiated this month with charts assigned to PT/RN/OT, and the Director of Clinical Services to review all new charts of RN case manager utilizing the chart checklist on a weekly basis. This will be completed by 1/21/14.</p> <p>See Addendum #2 and #3</p>		

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G 244	Continued From page 82 not been completed.  An agency evaluation had not been conducted.  2. The form "ANNUAL EVALUATION OUTLINE," dated 2013, did not include documentation of a clinical record review.  The DCS was interviewed on 12/31/13 beginning at 9:40 AM. She confirmed a clinical record review was not documented.	G 244			
G 245	A clinical record review had not been completed. 484.52 EVALUATION OF THE AGENCY'S PROGRAM  The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient.  This STANDARD is not met as evidenced by: Based on review of administrative records, meeting minutes, quality assurance documentation, and staff interview, it was determined the agency failed to ensure an annual agency evaluation was conducted which assessed the extent to which the agency's program was appropriate, adequate, effective and efficient. This resulted in a lack of feedback to agency staff to assist them to improve patient care. Findings include:  The agency's "Annual Evaluation" policy, dated 7/25/02, stated the purpose of the annual evaluation was "To assess the extent to which the agency's program is appropriate, adequate,	G 245	G 245  1/16/14 MultiCare Home Health conducted its Annual Program Evaluation.  See Addendum #2, and #3		

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G 245	Continued From page 83 effective, and efficient.  Meeting minutes titled "SemiAnnual Meeting," dated 12/06/13, were reviewed. The hand written minutes did not describe the purpose of the meeting. Items under the agenda were "Business Review, Marketing, and General." An organizational chart and some statistics, including numbers of admissions and discharges, were attached. Nothing was documented to indicate the meeting included the agency's annual evaluation. No determinations regarding the adequacy of services provided by the agency were documented.  The Administrator was interviewed on 12/19/13 at 2:30 PM. Stated the "SemiAnnual Meeting" on 12/06/13 was where the annual evaluation was discussed. She stated the meeting included the semi-annual PAC meeting and the governing body meeting. She confirmed the items discussed and the actions taken in relation to the evaluation were not documented. She stated no other documentation was present in 2013 to support an agency evaluation.	G 245			
G 248	484.52(a) POLICY AND ADMINISTRATIVE REVIEW  As part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective and efficient.	G 248	G 248  1/16/14 MultiCare Home Health conducted its Annual Program Evaluation.  See Addendum #2, and #3		

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G 248	Continued From page 84  This STANDARD is not met as evidenced by: Based on review of quality assurance documentation and staff interview, it was determined the agency failed to ensure agency policies were reviewed as part of the annual evaluation. This resulted in a lack of information that could be used to evaluate the agency's performance. Findings include:  The form "ANNUAL EVALUATION OUTLINE," with a hand written date of 2013 in the upper right hand corner, was 11 pages in total. The form was broken into categories of "Organization, Administration, Nursing Services, Therapy Services, Home Healthy [sic], Aide Service, and Coordination." The categories each had boxes to be marked with "Yes, No, Needs Improvement, Not Applicable, Comments, Goals & Plan." Each item on the form was marked "Yes." There were no comments for any item to indicate whether the item was sufficient or improvement was needed. For example:  Item "D. Personnel" stated "1. There are written personnel policies." There was an X in the Yes box. "2. Personnel practices are carried out according to the written policies." There was an X in the Yes box. Neither item included any description or other specific language to explain what was found.  The DCS was interviewed on 12/31/13 beginning at 9:40 AM. She stated she and the Assistant Administrator completed the "ANNUAL EVALUATION OUTLINE" form about 6 months ago but confirmed the evaluation was not dated. She stated the policies were in the process of being revised at the time and were not reviewed	G 248		

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G 248	Continued From page 85 as part of the evaluation.	G 248			
G 249	<p>Agency policies were not reviewed as part of the annual evaluation.</p> <p><b>484.52(a) POLICY AND ADMINISTRATIVE REVIEW</b></p> <p>Mechanisms are established in writing for the collection of pertinent data to assist in evaluation.</p> <p>This STANDARD is not met as evidenced by: Based on review of agency policies, quality assurance documentation, and staff interview, it was determined the agency failed to ensure mechanisms were established in writing for the collection of data for the evaluation. This resulted in a lack of guidance to staff conducting the evaluation. Findings include:</p> <p>The policy "Agency Evaluation," dated 7/25/12, stated "A group of agency personnel ... annually reviews the agency's policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation." The policy did not specify which forms to use or which quality indicators would be evaluated.</p> <p>The lack of specificity led to unclear objectives. For example, the above policy stated admission and discharge policies would be reviewed. However, the evaluation tool, titled "ANNUAL EVALUATION OUTLINE," did not contain questions about admission and discharge policies.</p>	G 249	<p>G 249</p> <p>MultiCare will ensure that the Annual Program Evaluation includes mechanisms established in writing for the collection of data for evaluation. The agency PAC, will meet at least semi-annually (more if needed) to review policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of care, clinical records, personnel qualifications, and overall program evaluation. This will ensure that any changes in policies are promptly addressed so that the agency is operating in compliance, and to ensure that the best possible care is being provided to the Patient's we serve. MultiCare Home Health conducted its Annual Program Evaluation on 1/16/14, and updated policies were included in the meeting minutes. The updated policies that were agreed upon by the PAC will be presented to the Governing Body on</p>		



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G 250	Continued From page 87 they had been completed.	G 250	Occupational Therapy, Speech Therapy, and Medical Social Worker).		
G 331	<p>A comprehensive review of open and closed records was not completed. Additionally, the agency did not utilize appropriate health professionals to review clinical records to determine whether established policies are followed</p> <p>484.55(a)(1) INITIAL ASSESSMENT VISIT</p> <p>A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure patient needs were accurately assessed during the initial assessment for 1 of 14 patients (#13) whose records were reviewed. This resulted in inaccurate patient diagnosis and misinformation dispersed to other disciplines. Findings include:</p> <p>1. Patient #13's medical record documented a 76 year old male admitted to the agency on 10/28/13 with diagnoses including shoulder dislocation after a fall, HTN, and dysmetabolic syndrome. His medical record for the certification period of 10/28/13 through 12/26/13 was reviewed.</p> <p>The initial assessment, completed by the CM on 10/28/13, identified primary diagnoses of aftercare for a traumatic fracture of the upper arm. Additional diagnoses included recurrent dislocation of the shoulder, dysmetabolic</p>	G 331	<p>A comprehensive review will be performed on both open and closed Patient charts that have been randomly selected, and will constitute a minimum of 10% of the average daily census of clients receiving each service offered during the quarter. The committee coordinator will select the charts to be audited and assign to various disciplines. The discipline will not be assigned to his/her own Patient to audit. The clinical records/quality sub-committee will review findings. The Director of Clinical Services will prepare a summary of findings, and will include an action plan to correct deficiencies. The summary and action plan will be reviewed with the interdisciplinary team during staff meetings and will include recommendations to improve care delivered to Patient, and documentation. The summary of findings will also be reviewed with the PAC at least annually. The Agencies next quarterly chart audit is March 2014, however the Director of Clinical Services has assigned audits to</p>		

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G 331	<p>Continued From page 88</p> <p>syndrome, HTN, cardiac murmurs, fall on stairs, disorder of thyroid, and insomnia.</p> <p>However, under "PERTINENT HISTORY AND/OR PREVIOUS OUTCOMES" the RN documented Patient #13 had a history of diabetes. In addition, in the "ENDOCRINE/HEMATOLOGY" section, the RN checked the box noting "The patient has a history of diabetes, thyroid problems, anemia, or gastrointestinal bleeding." There was no further documentation in the section to specify which endocrine or hematology problem or problems Patient #13 had a history of.</p> <p>Patient #13's POC, signed by the physician but not dated, did not include diabetes as a diagnosis. However, the POC documented Patient #13 was currently taking Metformin, a medication commonly used in the treatment of type II diabetes.</p> <p>A PTA visit note, documented 10/31/13, stated Patient #13's pharmacy was faxing Patient #13's physician for a new prescription to control blood sugar. The PTA documented Patient #13 did not have a glucometer and did not believe he had diabetes. The PTA documented he notified the CM of this and she called to make an appointment for Patient #13 to see his physician the next day for "BP/Type II diabetes follow up."</p> <p>An LPN visit note, documented 12/05/13, stated Patient #13 had been getting his food from the food bank but was having trouble adhering to his ADA diet because the food bank did not "have diabetic food."</p> <p>The CM reviewed the record and was interviewed</p>	G 331	<p>herself, the registered nurse, physical therapist, and occupational therapist this month. The chart audits assigned this month includes both open and closed charts, and will be reviewed at the next staff meeting on 1/21/14.</p> <p>The Director of Clinical Services will prepare a summary of results, and this will be reviewed at the next PAC meeting scheduled for 1/30/14. This will be completed by 1/21/14.</p> <p>See addendum #17, and #19</p> <p>G 331</p> <p>MultiCare will ensure that the registered nurse conducting the initial assessment of a Patient contains accurate assessment data clearly reflecting the Patient's condition. The case manager conducting the initial assessment of a Patient will make sure he/she has enough information regarding a Patient's condition to appropriately complete the initial assessment. If there has not been enough information provided the case manager will call the PCP to request</p>		

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G 331	Continued From page 89 on 12/19/13 at 8:10 AM. She stated Patient #13 did not have diabetes. She stated that during the assessment, she noted Patient #13 was taking Metformin and assumed it was for diabetes, but did not clarify with Patient #13 about why he was taking it. She stated she now knows Patient #13 was taking the Metformin to control his dysmetabolic syndrome, which she understood as a type of "pre-diabetes." She stated that when she realized Patient #13 was not actually diabetic, she did not include diabetes on the POC, but did not correct the initial assessment. She confirmed that this lead to a lack of clarity to other disciplines as to Patient #13's actual condition.	G 331	additional information. The diagnoses listed on the Plan of Care will be accurately documented throughout the Oasis assessment. The case manager will be responsible for instructing other disciplines involved in the Patient's plan of care regarding assessment findings, pertinent dx, and any other information that will assist that discipline in providing the best care possible to a Patient. The Director of Clinical Services will be checking charts with the case managers weekly, and has already been in-servicing case managers regarding initial assessment criteria. The case manager will notify the Director of Clinical Services when he/she has completed their initial assessment, and the Director of Clinical Services will review before the assessment is sent over as completed. This will be completed by 1/21/14.		
G 337	484.55(c) DRUG REGIMEN REVIEW  The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.  This STANDARD is not met as evidenced by: Based on record review, policy review, observations during home visits, and staff and patient interviews, it was determined the agency failed to ensure the drug review was comprehensive for 4 of 14 patients (#4, #5, #7, and #8) whose records were reviewed. Failure to obtain an accurate patient medication list or to evaluate the list for duplicative therapy, drug interactions, or significant side effects had the potential to place patients at risk for adverse	G 337	G 337  MultiCare will ensure that the comprehensive assessment of a Patient includes a review of all medications the Patient is currently		

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G 337	<p>Continued From page 90</p> <p>events or negative drug interactions. Findings include:</p> <p>1. Patient #8's medical record documented a 70 year old female admitted to the agency on 10/04/13 with diagnoses including lumbar sprain, back pain, and emphysema. Her medical record for the certification periods of 10/04/13 through 12/02/13 and 12/03/13 through 1/31/14 was reviewed. Patient #8's medication list was inaccurate as follows:</p> <p>a. The POC for the certification period 10/04/13 through 12/02/13 documented Patient #8 was dependent on supplemental oxygen and included "oxygen concentrator" under DME. However, documentation related to the amount and manner in which oxygen was supplied to Patient #8 was not included on the POC. The POC medication section noted Patient #8 was on "Medical air 2 LPM via NC continuous inhaled."</p> <p>The POC for the certification period of 12/03/13 through 1/31/14 also documented Patient #8 was dependent on supplemental oxygen, and included "oxygen concentrator" under DME, but oxygen was not included in the medication section of the POC. The POC again noted Patient #8 was on "Medical air 2 LPM via NC continuous inhaled" in the medication section.</p> <p>An observation of a PTA visit was made to Patient #8's home on 12/18/13 at 9:30 AM. It was noted Patient #8 was on continuous oxygen via NC at 2 LPM during the visit. Patient #8 confirmed she used oxygen continuously and did not use medical air.</p> <p>The DCS reviewed the record and was</p>	G 337	<p>taking, and any changes in the medication regimen throughout the certification period. The comprehensive assessment must include a review of all medications the Patient is currently taking in order to identify any potential adverse effects, and drug reactions, including ineffective drug therapy, side effects, drug interactions, duplicate drug therapy, and non-compliance with drug therapy. The medication profile for each Patient will have clear documentation, and will be updated throughout the cert period when changes in regimen occur. The medication profile will be reviewed with the Patient during visits, to include initial start of care (recert/resumption of care if indicated). The director of clinical services has in-serviced the Patient care team, and will have interdisciplinary team sign a memorandum of understanding at the next staff meeting on 1/21/14. This will be completed on 1/21/14.</p>	

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G 337	<p>Continued From page 91</p> <p>interviewed on 12/18/13 at 2:00 PM. She confirmed medical air was not an accurate treatment for Patient #8. She confirmed the POCs did not include Patient #8's use of oxygen via NC at 2 LPM despite identifying Patient #8 was dependent on supplemental oxygen.</p> <p>b. An LPN visit note, dated 11/07/13, documented Patient #8 had not had a BM in 6 days and "had gotten MOM to take although it was unopened. I went ahead and administered 30 mg to her while I was there..." There was no documentation to indicate MOM had been added to Patient #8's medication list and verified by the physician.</p> <p>An LPN visit note, dated 11/14/13, documented Patient #8 continued to experience constipation and had taken magnesium citrate in addition to the MOM. There was no documentation to indicate magnesium citrate had been added to Patient #8's medication list and verified by the physician.</p> <p>An LPN visit note, dated 11/27/13, documented Patient #8 continued to experience constipation and was taking Ex-Lax in addition to the MOM and magnesium citrate. There was no documentation to indicate Ex-Lax had been added to Patient #8's medication list and verified by her physician.</p> <p>The DCS reviewed the record and was interviewed on 12/18/13 at 2:00 PM. She confirmed the laxatives had not been added to Patient #8's medications or verified by Patient #8's physician to evaluate for duplicative therapies or interactions.</p>	G 337		

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G 337	<p>Continued From page 92</p> <p>Patient #8's POC was not updated to reflect all medications.</p> <p>2. Patient #4's medical record documented an 87 year old female admitted to the agency on 2/27/13 with diagnoses including A-fib, HTN, CVA, dementia and history of recent falls. Her medical record for the certification period of 2/27/13 through 4/27/13 was reviewed.</p> <p>A "DOCTORS ORDERS" form, dated 2/27/13, documented an order request stating "Please clarify the Prozasin [sic] 5 mg cap, rehab dc order is for once daily and you have her listed as taking it BID. Which dosing schedule would you like her to utilize?" The order request was signed by the physician on 3/05/13, but did not contain documentation of the physician's preferred dosing of the Prazosin.</p> <p>The POC documented Prazosin HCL 5 mg to be taken orally, twice a day. There was no documentation to indicate further contact with the physician had been made to clarify the order.</p> <p>The DCS reviewed the the record and was interviewed on 12/18/13 at 2:00 PM. She confirmed there was no documentation to indicate the order had been clarified with the physician to determine the correct dosing frequency for the Prazosin HCL.</p> <p>Medications were included on the POC without physician clarification.</p> <p>3. Patient #5 was a 48 year old female admitted to the agency on 9/10/13 for skilled nursing care related to CHF, lymphedema, and morbid obesity.</p>	G 337		

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G 337	<p>Continued From page 93</p> <p>The CM completed an assessment for recertification on 11/05/13, for the certification period 11/09/13 to 1/07/14. The assessment included a review of Patient #5's reported current medications.</p> <p>During a home visit on 12/17/13 at 10:00 AM, Patient #5 reviewed her medications as compared with the medications listed on her POC. The following discrepancies were noted as follows:</p> <ul style="list-style-type: none"> <li>- Drisdol 5,000 units to be taken once weekly on Tuesdays. Patient #5 stated she did not know what that medication was, or why it was listed that she was taking it.</li> <li>- Provera 10 mg, 2 tablets three times daily. Patient #5 stated she was taking 2 tablets twice daily.</li> <li>- Hydroxyzine 25 mg, 1 tablet three times daily for itching. Patient #5 stated she had been out of that medication for more than a month, and she no longer took it.</li> <li>- Effexor 75 mg, 1 capsule daily. Patient #5 stated she took 1-2 tablets daily, depending on how she felt. She stated if she felt more depressed, she would increase the dosage.</li> </ul> <p>During an interview with the CM on 12/19/13 beginning at 2:00 PM, she reviewed Patient #5's record and stated she was not aware that she was taking the medications differently than they were prescribed. The CM stated she had confirmed the medication list with Patient #5 during the recertification assessment and at that time the medications were current.</p>	G 337			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 337	<p>Continued From page 94</p> <p>Patient #5's medications were not accurately assessed.</p> <p>4. Patient #7 was a 90 year old male admitted to the agency on 8/18/13 for SN related a non-healing stasis ulcer on his leg. Additional diagnoses included HTN and arteriosclerotic vascular disease.</p> <p>The CM completed an assessment for recertification on 12/11/13, for the certification period 12/15/13 to 2/12/14. The assessment included a review of Patient #7's reported current medications.</p> <p>During a home visit on 12/18/13 at 7:30 AM, Patient #7's wife reviewed his medications as compared with the medications listed on his POC. The following discrepancies were noted as follows:</p> <ul style="list-style-type: none"> <li>- Natto Plus 2 capsules daily. Patient #7's wife was unaware of his taking this medication.</li> <li>- Loratadine 10 mg, 1 tablet daily for allergies. This medication was not on the POC.</li> <li>- Benadryl 25 mg, 1 tablet daily for allergies. This medication was not on the POC.</li> <li>- Neosporin pain relief ointment. Patient #7's wife stated she used the ointment occasionally on his leg wound to relieve pain. This medication was not on the POC.</li> </ul> <p>During an interview on 12/19/13 beginning at 10:00 AM, the CM reviewed Patient #7's record and confirmed the medication discrepancies.</p>	G 337		

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

PRINTED: 01/06/2014  
FORM APPROVED  
OMB NO. 0938-0391

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G 337	<p>Continued From page 95</p> <p>She stated Patient #7's wife continued to use Neosporin pain relief ointment on the wound, although she had recommended that she not use it. The CM stated the Natto Plus capsules was probably an error in data entry when she prepared the POC. She stated Natto Plus was an antihypertensive medication that Patient #7 was not taking. She stated she should have reviewed the POC for errors before sending it to the physician for signature.</p> <p>The agency failed to ensure a thorough review of patients' medications during comprehensive recertification assessments.</p>	G 337		
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N 000	16.03.07 INITIAL COMMENTS  The following deficiencies were cited during the state licensure survey of your home health agency conducted on 12/16/13 through 12/20/13.  The surveyors conducting the survey were:  Susan Costa, RN, HFS - Team Leader Gary Guiles, RN, HFS Libby Doane, RN, BSN, HFS  Acronyms used in this report include:  A-Fib - Atrial Fibrillation CM - Case Manager, an RN CVA - Cerebrovascular Accident DCS - Director of Clinical Services HTN - Hypertension LPN - Licensed Practical Nurse POC - Plan of Care RN - Registered Nurse SN - Skilled Nursing	N 000		
N 001	03.07020.01. ADMIN.GOV.BODY  020. ADMINISTRATION - GOVERNING BODY.  N001 01. Scope. The home health agency shall be organized under a governing body, which shall assume full legal responsibility for the conduct of the agency.  This Rule is not met as evidenced by: Refer to G130 as it relates to the Governing Body's failure to assume responsibility for the agency.	N 001	N 001  REFER TO G 130	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sharon Anitok</i>	TITLE Administrator	(X6) DATE 17-Jan-2014
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STATE FORM 6899 STOU11 If continuation sheet 1 of 8

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N 004	<p>03.07020. ADM.GOV.BODY</p> <p>N004 03. Responsibilities. The governing body shall assume responsibility for:</p> <p style="padding-left: 40px;">a. Adopting appropriate bylaws and policies and procedures.</p> <p>This Rule is not met as evidenced by: Refer to G130 as it relates to the Governing Body's failure to adopt appropriate policies and procedures.</p>	N 004	<p>N 004</p> <p>REFER TO G 130</p>	
N 092	<p>03.07024.01. SK.NSG.SERV.</p> <p>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:</p> <p>This Rule is not met as evidenced by: Refer to G143 as it relates to the lack of coordination of care between services.</p>	N 092	<p>N 092</p> <p>REFER TO G 143</p>	
N 102	<p>03.07024.SK.NSG.SERV.</p> <p>N102 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</p>	N 102	<p>N 102</p> <p>MultiCare will ensure that the registered nurse is making a visit to the Patient at least every 2 weeks to ensure that the registered nurse is reviewing the plan of care and</p>	

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N 102	<p>Continued From page 2</p> <p>following:</p> <p>j. For patients receiving care from a licensed practical nurse, the registered nurse reviews the plan of care and nursing services received at least every two (2) weeks and documents this in the patient's medical record.</p> <p>This Rule is not met as evidenced by: Based on record and policy review, and staff interview, it was determined the agency failed to ensure that skilled nursing services were provided under the supervision of a registered nurse for 2 of 14 patients (#4, #8) whose records were reviewed. This had the potential to result in inappropriate clinical decisions being made without the knowledge of the supervising RN. Findings include:</p> <p>The agency policy "Home Health Aide and Licensed Practical Nurse Supervisory Visits," revised 5/27/10, stated the RN will make a supervisory visit to the patient's home at least every 30 days to evaluate the LPN "...relationships and determine whether Patient goals/needs are being met." The policy did not include a method to ensure the RN reviewed the POC and nursing services at least every 2 weeks. Nursing services were not reviewed by the RN at least every 2 weeks as follows:</p> <p>1. Patient #8's medical record documented a 70 year old female admitted to the agency on 10/04/13 with diagnoses including lumbar sprain, back pain, and emphysema. Her medical record for the certification periods of 10/04/13 through 12/02/13 and 12/03/13 through 1/31/14 were</p>	N 102	<p>supervising licensed practical nursing services to keep inappropriate clinical decisions from being made without the knowledge of the registered nurse. This policy has been updated and will be presented to the PAC for review on 1/30/14, and will be presented to the Governing body for approval and adoption on 2/27/14. Interdisciplinary team has been in-serviced by the Director of Clinical Services, and the registered nurses have scheduled a supervisory visit with Patient's at least every 2 weeks. The team will sign a memorandum of understanding at the next staff meeting on 1/21/14. This will be completed on 1/21/14.</p>	
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N 102	<p>Continued From page 3 reviewed.</p> <p>The POC for the certification period of 10/04/13 through 12/02/13 documented Patient #9 was to receive SN visits 1-2 times a week for 9 weeks. LPN visits were documented on 10/16/13, 10/23/13, 11/07/13, 11/14/13, 11/21/13, and 11/27/13.</p> <p>RN supervisory visits were conducted on 10/30/13 and 12/02/13, 33 days apart.</p> <p>The DCS reviewed the record and was interviewed on 12/18/13 at 2:00 PM. She confirmed supervisory visits had not been provided in accordance with agency policy. She also confirmed there was no documentation to indicate the RN assessed nursing services provided by the LPN at least every 2 weeks.</p> <p>The RN did not assess care provided by the LPN at least every 2 weeks.</p> <p>2. Patient #4's medical record documented an 87 year old female admitted to the agency on 2/27/13 with diagnoses including A-fib, HTN, CVA, dementia and history of recent falls. Her medical record for the certification period of 2/27/13 through 4/27/13 was reviewed.</p> <p>The POC documented SN visits were to be performed 1-2 times a week for 9 weeks. Seven LPN visits were made to Patient #4, on 3/05/13, 3/13/13, 3/20/13, 3/27/13, 4/02/13, and 4/11/13. Two RN supervisory visits were made on 3/22/13 and 4/16/13, 25 days apart.</p> <p>The DCS reviewed the record and was interviewed on 12/18/13 at 2:00 PM. She confirmed there was no documentation to</p>	N 102		
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N 102	Continued From page 4  indicate the RN assessed nursing servics provided by the LPN at least every 2 weeks. .  The RN did not assess care provided by the LPN at least every 2 weeks.	N 102		
N 151	03.07030.PLAN OF CARE  N151 030. PLAN OF CARE. Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's plan of care.  This Rule is not met as evidenced by: Refer to G157 as it relates to the failure of the agency to ensure it could provide ordered services to patients.	N 151	N 151  REFER TO G 157	
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 agency to ensure patient care followed a written plan of care.	N 152	N 152  REFER TO G 158	
N 153	03.07030.PLAN OF CARE  N153 01. Written Plan of Care. A written plan of care shall be	N 153	N 153  REFER TO G 159	

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N 153	Continued From page 5  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 the plan of care covered all pertinent diagnoses.	N 153		
N 155	03.07030. PLAN OF CARE  N155 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes:  c. Types of services and equipment required;  This Rule is not met as evidenced by: Refer to G159 as it relates to the failure of the agency to ensure patients' POCs included all necessary services and equipment.	N 155	N 155  REFER TO G 159	
N 172	03.07030.06.PLAN OF CARE  N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.  This Rule is not met as evidenced by:	N 172	N 172  REFER TO G 164	

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N 172	Continued From page 6  Refer to G164 as it relates to the failure of the agency to ensure agency professional staff alert the physician to any changes that suggest a need to alter the plan of care.	N 172		
N 186	03.07031.03.CLINICAL REC.  N186 03. Clinical and Progress Notes, and Summaries of Care. Clinical and progress notes must be written or dictated on the day service is rendered and incorporated into the clinical record within seven (7) days. Summaries of care reports must be submitted to the attending physician at least every sixty (60) days.  This Rule is not met as evidenced by: Based on staff interview and review clinical records and agency policies, it was determined the agency failed to ensure progress notes were written on the day of service for 1 of 14 patients (#1) whose records were reviewed. This prevented staff from accessing medical record information in a timely manner. Findings include:  Patient #1's medical record documented an 85 year old female who was admitted to the agency on 7/15/13 and was discharged on 10/29/13. Her diagnoses included fractured lumbar vertebra, osteoporosis, and diabetes.  Patient #1's "OCCUPATIONAL THERAPY EVALUATION" stated it was conducted on 8/29/13 between 12:30 PM and 1:45 PM. The evaluation stated it was not completed until 9/02/13 at 2:59 PM, 4 days after the evaluation visit. An "OCCUPATIONAL THERAPY VISIT NOTE" stated it was conducted on 8/31/13	N 186	N 186  MultiCare will ensure that visiting interdisciplinary team members are entering and electronically signing their visit notes the day the service is rendered, and then completing and sending the visit to the agency for completion within 24 hours of the visit to the Patient. The only exception to this policy would be that the electronic device was not functioning properly in the Patient's home, and the visiting team member did not have access to a computer to put the note in. The visit note will still need to be completed and sent to the office within 24 hours of the visit. This policy has been updated and will be presented to the PAC on 1/30/14, and then presented to the Governing Body for approval and adoption on 2/27/14. Interdisciplinary team members have been in-serviced by the Director of Clinical Services. The assistant administrator will be tracking visit	

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N 186	Continued From page 7  between 1:00 PM and 1:30 PM. The note stated it was not completed until 9/02/13 at 3:27 PM, 2 days after the evaluation visit. Another "OCCUPATIONAL THERAPY VISIT NOTE" stated it was conducted on 9/11/13 between 2:30 PM and 3:00 PM. The note stated it was not completed until 9/15/13 at 4:47 PM, 4 days after the evaluation visit.  The DCS was interviewed on 12/19/13 beginning at 9:25 AM. She reviewed Patient #1's clinical record and confirmed the OT documentation was not completed on the day of service.	N 186	notes daily. The team members will sign a memorandum of understanding at the next staff meeting on 1/21/14. This will be completed on 1/21/14.	
N 193	03.07040.AGENCY EVALUATION  N193 040. AGENCY EVALUATION. A group of professional personnel, which includes at least one (1) physician, one (1) registered nurse, and with appropriate representation from other professional disciplines, establishes and annually reviews the agency's policies governing the scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one (1) member of the group is neither an owner nor an employee of the agency.  This Rule is not met as evidenced by: Refer to G242 as it relates to the failure of the group of professional personnel to evaluate the agency's program.	N 193	N 193  REFER TO G 242	