

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



IMPORTANT NOTICE – PLEASE READ CAREFULLY

January 22, 2015

Matthew Hoskins, Administrator
Touchmark Home Health
210 S. Touchmark Way
Meridian, Idaho 83642

CMS Certification Number: 13-7092

**Re: Recertification survey 12/22/2014 found Conditions of Participation Not Met
Suspension of payments for new admissions if not back in compliance by 02/22/2015
Mandatory Termination if not back in compliance by 06/22/2015**

Dear Mr. Hoskins:

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

I. BACKGROUND

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

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

On December 22, 2014, the Idaho Bureau of Facility Standards (State survey agency) completed a recertification survey at your facility and found five deficiencies including an Immediate Jeopardy (42 CFR 484.55 Comprehensive Assessment, Tag G337) which was removed at the time prior to exit date of the survey.

CMS agrees with the State survey agency that the following conditions were not met:

- 42 CFR 484.14 Organization, Services, and Administration
- 42 CFR 484.18 Acceptance of Patients, Plan of Care and Medical Supervision
- 42 CFR 484.30 Skilled Nursing Services
- 42 CFR 484.52 Evaluation of the Agency's Program
- 42 CFR 484.55 Comprehensive Assessment of Patients - IJ abated

The identified deficiencies have been determined to be of such serious nature as to substantially limit your agency's ability to provide adequate and safe care.

I. ALTERNATIVE SANCTIONS

Because Touchmark Home Health is not in compliance with the Conditions of Participation with the Medicare Program, CMS is imposing the following alternative sanction:

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

This is effective for new Medicare admissions made on or after **February 22, 2015**. This denial of payment for new admissions also applies to Medicare patients who are members of managed care plans. If Touchmark Home Health does not meet all the home health agency Conditions of Participation, its Medicare provider agreement will be terminated no later than **June 22, 2015**. CMS publish a legal notice in the local newspaper at least **fifteen days** prior to the termination date.

III. APPEAL RIGHTS

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

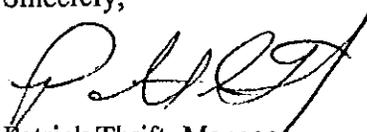
Chief, Civil Remedies Division Departmental Appeals Board MS 6132 Cohen Building, Room 637-D 330 Independence Avenue, SW Washington, D.C. 20201	Please also send a copy to:	Chief Counsel DHHS Office of General Counsel 701 Fifth Avenue, Suite 1620 MS RX -10 Seattle, WA 98104
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Page 3 – Mr. Hoskins

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

If you have further questions, please contact Fe Yamada of my staff at (206) 615-2381 or by email at marie.yamada@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink, appearing to read 'P. Thrift', written over a horizontal line.

Patrick Thrift, Manager
Regional Office - Seattle
Division of Survey, Certification and Enforcement

cc: Idaho Bureau of Facility Standards



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

January 12, 2015

Matthew Hoskins, Administrator
Touchmark Home Health
210 S. Touchmark Way
Meridian, Idaho 83642

RE: Touchmark Home Health CNN 13-7092

Dear Mr. Hoskins:

Based on the survey completed at Touchmark Home Health, on December 22, 2014, by our staff, we have determined the agency is out of compliance with five Medicare Home Health Agency (HHA) **Conditions of Participation:**

- **Organization, Services, and Administration [42 CFR 484.14],**
- **Acceptance of Patients, Plan of Care, and Medical Supervision [42 CFR 484.18],**
- **Skilled Nursing Services [42 CFR 484.30],**
- **Evaluation of the Agency's Program [42 CFR 484.52], and**
- **Comprehensive Assessment of Patients [42 CFR 484.55].**

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 the conditions to be unmet, substantially limit the capacity of Touchmark Home Health to furnish services of sufficient level and quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

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

Mathew Hoskins, Administrator
January 12, 2015
Page 2 of 3

An acceptable Plan of Correction contains the following elements:

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

Please complete your Allegation of Compliance/Plan of Correction and submit it to this office by **January 22, 2015.** The Credible Allegation/Plan of Correction for each Condition of Participation and related standard level deficiencies must show compliance no later than **February 5, 2015** (45 days from the survey exit date). We may accept the Credible Allegation of Compliance/Plan of Correction and presume compliance until a revisit survey verifies compliance.

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

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

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

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

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

In accordance with 42 CFR 488.745, you have one opportunity to question the deficiencies that resulted in the Conditions of Participation being found out of compliance through an informal

Mathew Hoskins, Administrator
January 12, 2015
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dispute resolution (IDR) process. To be given such an opportunity, you are required to send your written request and all required information as directed in the attached document. This request must be received by **January 22, 2015**. If your request for IDR is received after **January 22, 2015**, the request will not be granted. An incomplete IDR process will not delay the effective date of any enforcement action. If the agency wants the IDR panel to consider additional evidence, the evidence and six (6) copies of the evidence must be received 15 calendar days before the IDR meeting [Refer to page 6 of the attached IDR Guidelines].

This letter replaces the letter previously issued on January 9, 2015.

We urge you to begin correction immediately.

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

Sincerely,



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/

Enclosures

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2014
NAME OF PROVIDER OR SUPPLIER TOUCHMARK HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 210 SOUTH TOUCHMARK WAY MERIDIAN, ID 83642	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your home health agency completed 12/15/14 through 12/22/14. Surveyors conducting the recertification were: Don Sylvester, RN, HFS, Team Leader Laura Thompson, RN, HFS Sylvia Creswell, LSW, HFS, Supervisor The following acronyms were used in this report: CAD - Coronary Artery Disease CDC - Centers for Disease Control CNA - Certified Nursing Assistant DM - Diabetes Mellitus H & P - History and physical HHA - Home Health Aide HTN - Hypertension IR - Immediate release Lpm - Liters per minute Mg - milligrams OT - Occupational Therapist PEG - Percutaneous Endoscopic Gastrostomy tube POC - Plan of Care PRN - as needed PT - Physical Therapist Pt - Patient RN - Registered Nurse ROC - Resumption of Care SN - Skilled Nurse SOC - Start of Care ST - Speech Therapist TED Hose- Thromb Embolic Deterrent stockings	G 000		
G 107	484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP	G 107		

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JAN 22 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

Administrator

(X6) DATE

1/22/15

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.

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

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FORM APPROVED
OMB NO. 0938-0391

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RECEIVED
FEB - 9 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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G 107	<p>Continued From page 1</p> <p>The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, agency policies, and review of quality improvement documents, it was determined the agency failed to ensure complaints were reviewed, investigated, and documented. This prevented the agency from determining whether care provided to patients was appropriate. Findings include:</p> <p>The agency policy, number 5.4 "Investigation of Complaints" dated 4/07, stated a complaint made by phone or letter will be directed to the Administrator and/or the Director of Professional Services, or designee, and will be promptly recorded. The client or person making the complaint will be informed of the complaint resolution as soon as possible after the resolution actions have been taken.</p> <p>The Director of Professional Services was interviewed on 12/17/14 beginning at 3:00 PM. She stated she had been with the agency since August 2014, and no complaints had been received during the last 4 months. The Director of Professional Services stated the prior Director of Professional Services had thrown out the agency's complaints binder, which held the agency's complaints. She confirmed there was no</p>	G 107	<p>A Patient Complaint Binder has been created. It will be housed in Director's office for all complaints to be addressed and resolved. Staff in-serviced on use, new form and importance of tracking patient complaints. Please see Attachments: 1,2,3,4,51</p> <p>Accurately tracking and resolving patient complaints allows for regulation compliance, but also increases education opportunities for better overall patient satisfaction and care delivery. The new form allows recognition and correction by director level position. Will be monitored monthly by Clinical Supervisor and tracked on monthly tracking form.</p>	1/14/15

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G 107	Continued From page 2 documentation to show complaints were investigated and/or resolved.	G 107	Responsible Person - Home Health Director		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on observation, policy review, staff interview, and review of medical records, it was determined the agency failed to ensure staff complied with accepted standards of practice related to infection control. This impacted 2 of 6 patients (#1 and #8) whose home visits were observed. These failures had the potential to introduce or facilitate the spread of infection. Findings include: The CDC website, accessed on 1/05/15, stated there are key situations in which hand washing should be performed. Those situations are: before touching a patient (even if gloves will be worn), before exiting the patient's care area after touching the patient or the patient's immediate environment, after contact with blood, body fluids or excretions, or wound dressings, and after glove removal. The CDC also stated good hand hygiene, including use of alcohol-based hand rubs and handwashing with soap and water, is critical to reduce the risk of spreading infections. The agency policy, number 16.2 "Infection	G 121	Staff in-service given on proper handwashing technique and demonstration required. CDC and World Health Organization guidelines were utilized and taught. Please see attachments: 5,6,7,8,9 Clinicians were in-serviced on a handwashing refresher course. Infection control is and will remain top priority for Touchmark Home Health's agency. Will be monitored by Clinical Supervisor and added to yearly education requirement.	1/14/15	

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G 121	<p>Continued From page 3</p> <p>Control Policies" dated 8/11, stated hands would be washed by staff members before and after client care, before handling anything clean, after handling anything contaminated, and when obviously soiled. It also stated hands should be washed frequently, especially immediately following accidental contact with blood and/or any moist body substance.</p> <p>RN's did not follow the agency's policy or CDC guidelines when providing patient care. Examples include:</p> <p>1. Patient #8 was a 71 year old male admitted to the agency on 10/19/14, for treatment of decubitus ulcers. Additional diagnoses included non-surgical wound dressing changes, diabetes type II, long-term insulin use, and dementia. He received SN and PT services. His record, including the POC, for the certification period 10/19/14 to 12/17/14, was reviewed.</p> <p>During a home visit on 12/16/14 beginning at 12:50 PM, the RN Case Manager was observed performing wound care. The following infection control breaches were noted during the visit.</p> <p>-The RN washed her hands in the bathroom and put gloves on. She then removed Patient #8's shoes and raised his left pant leg. A small tan stain was observed on his TED hose, on the top of his foot. The RN removed the TED Hose, exposing a small open wound on the top of his foot. The RN removed her gloves and disposed of them.</p> <p>-The RN Case Manager pulled out a bag of white gauze and a wound cleanser bottle, using her bare hands. She then re-gloved without washing</p>	G 121	<div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>Person Responsible: Clinical Supervisor</p> </div>		

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G 121	<p>Continued From page 4</p> <p>her hands. She opened the bag and pulled out a 4x4 gauze dressing. The RN then sprayed the wound with wound cleanser and patted the wound with the gauze. She placed the used gauze in a bag, and reached into the bag for more gauze with her contaminated gloves. She did not remove her gloves, wash her hands, and re-glove, before obtaining additional gauze.</p> <p>-The RN dressed the wound and reapplied Patient #8's TED hose. She removed her gloves and washed her hands.</p> <p>The RN who provided care for Patient #8 was interviewed on 12/17/14 at 12:00 PM. She confirmed she did not wash her hands between glove changes, and placed her contaminated gloves in the bag of clean white gauze.</p> <p>Agency staff did not adhere to accepted standard of practice related to infection control.</p> <p>2. Patient #1 was an 86 year old female admitted to the agency on 10/27/14 for SN and PT services. Diagnoses included left ankle wound, abnormal gait, post-traumatic wound infection, muscle weakness, and history of fall. Patient #1's record including the POC, for the certification period 10/27/14 to 12/25/14, was reviewed.</p> <p>A visit was made to the assisted living facility, where Patient #1 resided, on 12/15/14 beginning at 1:15 PM. The RN Case Manager was observed performing wound care. The following infection control breaches were observed during the visit.</p> <p>-The RN Case Manager washed her hands in the</p>	G 121			

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G 121	<p>Continued From page 5</p> <p>bathroom and put on gloves. She then elevated Patient #1's left leg and removed her slipper. The RN cut the wound dressing from the left lower extremity, with scissors from her nursing supply bag. The old dressing was observed to have a scant amount of dark colored drainage from the left ankle wound. She removed her gloves and disposed of them.</p> <p>- The RN laid out her supplies for the dressing change. She laid a paper barrier next to Patient #1's leg and, using her bare hands, pulled out a 4x4 gauze dressing, wound cleanser, wound packing medication, and antibiotic ointment from a plastic bag.</p> <p>- The RN used the same scissors to cut Coban dressing (a special dressing that adheres to itself) for the new wound dressing. She did not clean the scissors after using them to cut the old wound dressing. She proceeded to spray wound cleanser onto the 4x4 gauze.</p> <p>-The RN then removed another pair of gloves from her supply bag and put them on, without washing her hands. She applied a numbing gel to the wound on the left lateral ankle. After waiting a few minutes she picked up the same 4x4 gauze and cleaned the wound. She then picked up another 4x4 gauze, wrapped it around the blunt end of a cotton tipped applicator, and used it to clean the inside of the wound. The RN Case Manager cleaned inside the wound 3 times, with the same 4x4 gauze.</p> <p>- The RN applied a new dressing to the wound without changing her gloves, or washing her hands. She used a cotton tip applicator to pack the wound with medicated gauze, applied the</p>	G 121			

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G 121	Continued From page 6 antibiotic ointment with a different cotton tipped applicator, and covered the wound with a foam dressing. -The RN then wrapped Patient #1's left lower extremity with a white coated gauze dressing, which started at the foot and wrapped up the entire calf. She then wrapped the left lower extremity with the Coban. The RN removed her gloves, disposed of them, and washed her hands in the bathroom. During an interview on 12/18/14 at 9:55 AM, the RN Case Manager who provided the wound care confirmed she did not wash her hands between changing gloves or clean her scissors after using them to remove the soiled dressing. The RN Case Manager did not adhere to accepted standards of practice and agency policy related to infection control.	G 121			
G 122	484.14 ORGANIZATION, SERVICES & ADMINISTRATION This CONDITION is not met as evidenced by: Based on staff interview, review of patient records, and review of administrative documents, it was determined the Governing Body failed to provide necessary organizational and administrative controls and oversight of agency practices, policies, and procedures. This failure resulted in a lack of support and guidance to agency personnel. Findings include:	G 122	Multiple changes to leadership and governance are as follow: Please see changes next to corresponding G tags:		

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NAME OF PROVIDER OR SUPPLIER TOUCHMARK HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 210 SOUTH TOUCHMARK WAY MERIDIAN, ID 83642		
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G 122	Continued From page 7 1. Refer to G128 as it relates to the Governing Body's failure to ensure the overall effective operation of the HHA. 2. Refer to G137 as it relates to the Governing Body's failure to ensure a qualified person is authorized in writing to act in the absence of the administrator. 3. Refer to G144 as it relates to the Governing Body's failure to ensure effective interchange, reporting, and coordination of patient care occurred. 4. Refer to G155 as it relates to the Governing Body's failure to ensure meeting minutes were documented.	G 122			
G 128	The cumulative effect of these systemic failures seriously impeded the ability of the agency to provide services of sufficient scope and quality. 484.14(b) GOVERNING BODY A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the operation of the agency. This STANDARD is not met as evidenced by: Based on staff interview, policy review, and review of job descriptions and corporate documents, it was determined the agency's governing body failed to assume responsibility for the operation of the agency. This resulted in a lack of leadership and direction to agency personnel. Findings include: 1. The agency was owned by a corporation	G 128	New PAC Meeting format created with all information and comment period to be sent to members of governing body. IDAPA 16.03.07 was the regulation used to develop this format. Accurate record keeping and minutes to be taken at meeting. Also, please note Agency Evaluation, QI, Policy and Procedure review, and Agency Operations report added to meeting agenda. PAC Meeting	2/4/15	

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G 128	<p>Continued From page 8 which operated the agency.</p> <p>The Administrator was interviewed on 12/19/14 beginning at 9:00 AM. He acknowledged, the Director of Professional Services had direct oversight of the home health agency for the day to day operations.</p> <p>The Director of Professional Services was interviewed on 12/18/14 beginning at 12:46 PM. When asked, she indicated minutes showing the Governing Body's oversight of the operations of the agency were not available. There was no documentation that the corporate owner had provided oversight of the agency in the past year. The only documentation provided pertaining to the Governing Body's oversight of the agency, was a document titled Professional Agency Committee, which contained a quarterly review of financial details and marketing information.</p> <p>There was no record of supervision or oversight by the governing body.</p> <p>2. The Governing Body failed to ensure a program to evaluate the agency's performance had been developed and implemented.</p> <p>Policies and procedures outlining a process to evaluate the agency's total program had not been implemented. In addition, a process to conduct medical record reviews for quality assurance purposes had not been implemented. An agency evaluation or data that had been collected for quality improvement purposes was not implemented.</p> <p>The Director Professional Services was interviewed on 12/17/14 beginning at 1:45 PM.</p>	G 128	<p>Cont.</p> <p>to occur on Feb. 4th, 2015 Quarterly Chart Audit Review binder, tracking format, and process. All clinicians to rotate chart audits to improve charting and improve performance. Audits to then be tracked and trends identified, discussed, and remedied. Governing Body meetings to be held in conjunction with PAC Meetings. See attachments: 10,11,12,13,14,15,16,17,52</p> <p>Proper PAC protocol, consistent chart audits, performance tracking, QI, and agency evaluations will improve overall delivery of care and allow for better measurement and care standards. Accurate record keeping and storage will also help to improve year over year comparisons. Resulting in improved processes and quality of care.</p>	

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G 128	Continued From page 9 She confirmed a quality program had not been implemented. She stated policies had been developed but she said no quality indicators had been developed. She stated no specific data regarding care provided, or whether agency policies were followed, had been collected. She stated data from medical record reviews had not been gathered and utilized for quality improvement. She confirmed the quarterly Professional Agency Committee meeting minutes for 2013 and 2014 did not address the agency's quality program or mention quality data.	G 128	Person Responsible: Home Health Director	
G 137	The Governing Body did not ensure an annual evaluation program was implemented. 484.14(c) ADMINISTRATOR A qualified person is authorized in writing to act in the absence of the administrator. This STANDARD is not met as evidenced by: Based on staff interview and review of administrative documents, it was determined the agency failed to authorize in writing a qualified person to act in the absence of the Administrator. This had the potential to interfere with availability of a qualified person in the absence of the Administrator. Findings include: During an interview on 12/19/14 beginning at 9:00 AM, the Administrator stated the Director of Professional Services was the designated Administrator in his absence. Documentation supporting the statement was not provided by the agency. During an interview on 12/17/14 at 2:25 PM, the	G 137	Letter was drafted and signed assigning Home Health Director in charge in absence of Administrator as well as placing Clinical Supervisor in charge if both Administrator and Director are unavailable. See Attachment: 17 Clarity and assignment of responsibility will help all in knowing chain of command for HHA operation.	12/23/14

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G 137	Continued From page 10 Director Professional Services was asked who was authorized to act in the absence of the Administrator. She stated she would act in the Administrator's absence, however she was unable to provide a written statement to document this.	G 137	Person Responsible: Home Health Director	
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on staff interview, and review of medical records, it was determined the agency failed to ensure care coordination between disciplines was documented for 5 of 13 patients (#1, #5, #7, #10, and #13) who received services from more than one discipline and whose records were reviewed. This had the potential to interfere with quality and continuity of patient care. 1. Patient #1 was an 86 year old female admitted to the agency on 10/27/14 for SN and PT services. Diagnoses included left ankle wound, abnormal gait, post-traumatic wound infection, muscle weakness, and history of fall. Patient #1's record including the POC, for the certification period 10/27/14 to 12/25/14, was reviewed.	G 144	A new case conference binder and process created. Clearly defined agenda and new care coordination forms utilized. New Care Coordination forms to be used for all types of care coordination. Paper color to be blue to clearly demonstrate care communication and remind clinicians importance of documenting all communication and coordination of patient care plans. Continued...	1/15/15

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G 144	<p>Continued From page 11.</p> <p>Visit notes for Patient #1 from 10/27/14 to 12/15/14, were reviewed for documentation of coordination of care between the disciplines. There were 17 nursing visits and 10 physical therapy visits.</p> <p>- Nursing visit notes, dated 11/24/14 and 12/08/14, documented under "Care Coordination," the physical therapist was contacted. The RN did not include details of when the physical therapist was contacted, or what information was communicated.</p> <p>- The physical therapist notes, dated 11/11/14, 11/13/14, 11/18/14, and 11/20/14 documented under "Care Coordination," the nurse was contacted about Patient #1's confusion. The PT did not include details of when the RN was contacted, or what information was communicated.</p> <p>During an interview on 12/18/14 at 9:55 AM, the RN Case Manager reviewed Patient #1's record and confirmed coordination between disciplines was not documented. She stated discussions about patients and their care would often take place in the agency office, but this was not documented in the patients' records.</p> <p>Coordination of care among personnel furnishing care to Patient #1 was not documented.</p> <p>2. Patient #7 was a 96 year old female admitted to the agency on 11/22/14 for SN, PT, and HHA services. Diagnoses included surgery, pacemaker, atrial fibrillation, broken heart syndrome, heart attack, history of fall, and urinary tract infection. Patient #7's record, including the POC, for the certification period 11/22/14 to</p>	G 144	<p>Inservice given to staff on proper care coordination and importance of adequate documentation. Also educated on importance of discussing all out of range patient condition changes, medication changes, or overall status changes among all disciplines involved for improved care and patient outcomes.</p> <p>Please see attachments: 18,19,20,21,22,23,24,25,26</p> <p>Thorough communication and documentation improvements will help maximize care efficiency and create a better plan of care for patients. Establishing effective communication avenues increases understanding of patient conditions and status changes. It also helps to recognize improvements or declines quicker for faster intervention management.</p>		

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G 144	<p>Continued From page 12 1/20/15, was reviewed.</p> <p>Patient #7's record had a verbal order written by the Clinical Director, dated 12/03/14, which stated all clinician visits were on hold until Patient #7 was seen by the physician, on 12/02/14. However, the record documented an RN SOC visit, on 11/22/14 and a physical therapy evaluation visit, dated 11/25/14.</p> <p>During an interview on 12/17/14 at 1:40 PM, the Clinical Director reviewed the record and confirmed she had written the verbal order. The Clinical Director was requested to clarify what the order meant. She stated after the physical therapy evaluation on 11/25/14, she contacted the physician for verbal approval for the physical therapy plan of care. The physician had informed her, at that time, no further disciplines were to visit Patient #7 until she was seen by him on 12/02/14. The Clinical Director stated she was unsure which date or what time she had spoken to the physician. She further stated this order was communicated to the PT and RN, but confirmed it was not documented in the record.</p> <p>- The physical therapist notes dated 11/25/14, 12/04/14, 12/06/14, 12/09/14, 12/12/14, and 12/15/14 documented under "Care Coordination," the nurse was contacted about Patient #7's care. The PT did not include details of when the RN was contacted, or what was communicated.</p> <p>- A nursing intervention note dated 12/12/14, documented under "Care Coordination," the physical therapist was contacted. The RN did not include details of when the physical therapist was contacted, or what was communicated.</p>	G 144	<p>There will also be increased understanding of expectations and physician order adherence and compliance with the new communication forms and process. Will be monitored by Clinical Supervisor during review of Oasis completion and patient notes.</p> <p>Persons Responsible: Clinical Supervisor</p>	

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G 144	<p>Continued From page 13</p> <p>During an interview on 12/18/14 at 11:50, the RN Case Manager reviewed the record and confirmed the note indicated the PT was contacted. She also confirmed the specifics of what was communicated were not documented. The RN Case Manager stated many discussions regarding patients take place in the agency office, but they are not documented in patient records.</p> <p>Coordination of care among personnel furnishing care to Patient #7 was not documented.</p> <p>3. Patient #10 was a 71 year old female admitted to the agency on 11/14/14, for SN, PT, and OT services. Diagnoses included pneumonitis due to inhalation of vomitus or food, multiple sclerosis, chronic pain, depression, and intestinal infection. Patient #10's record, including the POC, for the certification period 11/14/14 to 1/12/15, was reviewed.</p> <p>a. A physical therapy note dated 12/04/14, and signed by the PTA, documented Patient #10 fell from her bed in the morning and bumped her forehead on the dresser. The PTA also documented a 1 inch cut to the left side of Patient #10's forehead. Under the care coordination section, the PTA documented the RN Case Manager was contacted. However, the note did not include details of when the RN was contacted, or what was communicated. There was no documentation the physician was notified.</p> <p>The following day, 12/05/14, the RN Case Manager documented in her nursing intervention note that Patient #10 had fallen 3 times that morning. She also noted Patient #10 was feeling weak and dizzy, resulting in frequent falls. However, there was no documentation about the</p>	G 144	<p>Inservice given to staff to discuss and educate on importance of communication and reporting to physician for any change in patient condition, change to POC, status change, etc. included importance of proper and complete documentation and gathering of orders for any change to POC. Please see attachments: 18,19,20,21,22,23,24,25,26</p> <p>Increased and more complete communication with physicians will not only improve patient care but guarantee compliance and consistency with care plan management. Inservice provided better understanding of all items needing to be reported to physicians and reasoning behind their needing to know. One form for all communication also simplifies process and helps to demonstrate and track communication being done. Continued</p>	

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G 144	<p>Continued From page 14</p> <p>cut on Patient #10's forehead or communication with the PTA. Under the care coordination section, the RN Case Manager documented PT, OT, and Patient #10's significant other were contacted. However, the note did not include details of when the PT, OT, or significant other were contacted, or what information was communicated. There was no documentation the physician was notified.</p> <p>b. A physical therapy note dated 12/12/14, and signed by the PT, stated Patient #10 had taken 4 oxycodone tablets for low back pain. However, there was no documentation related to when the medication was taken by Patient #10. The pain medication was not listed on Patient #10's POC or medication list. There was no documentation the RN Case Manager, OT, or physician were contacted.</p> <p>On the same physical therapy note the PT also documented 4 different blood pressure measurements: 94/64, 111/64, 131/75, and 125/65. She documented Patient #10 went to her physician one week ago and was diagnosed with postural hypotension (a form of low blood pressure that occurs when you stand up from sitting or lying down). The PT did not document contacting the RN Case Manager or physician about Patient #10's irratic blood pressure levels.</p> <p>During an interview on 12/17/14 at 9:15 AM, the RN Case Manager reviewed the record. She confirmed she did not notify Patient #10's physician of Patient #10's falls or injuries. The RN Case Manager stated Patient #10 told her she would make an appointment with her physician. She also stated she did discuss her concerns about Patient #10 with other disciplines,</p>	G 144	<p>Continued:</p> <p>The long term relationship between the physicians and the patients we care for will also greatly improve with the increased communication and coordination. Thorough communication and broader awareness provides security to patients and caregivers that every member of their health care team is on the same plan. Will be monitored by Clinical Supervisor during review of Oasis completion and patient notes.</p> <p>Persons Responsible: Clinical Supervisor</p>	

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G 144	<p>Continued From page 15 but confirmed this was not documented in the record.</p> <p>During an interview on 12/19/14 at 1:15 PM, the PT confirmed she documented about the pain medication and blood pressure measurements. She confirmed she did not contact the physician. The PT stated she did speak with the RN Case Manager but it was not documented in the record. She stated the PTA was no longer employed by the agency.</p> <p>Coordination of care among personnel furnishing care to Patient #10 was not documented.</p> <p>4. Patient #13 was a 91 year old male admitted to the agency on 11/13/14 for SN and PT services. Diagnoses included gallstones, coronary atherosclerosis, diabetes mellitus, pulmonary fibrosis, depression, B-complex deficiencies, and supplemental oxygen. Patient #13's record, including the POC, for the certification period 11/13/14 to 1/11/15, was reviewed.</p> <p>Patient #13's POC included oxygen to be set at 2 lpm at rest and 4 lpm with exertion. The Mayo Clinic website, accessed on 12/24/14, stated normal oxygen saturation levels range from 95 to 100 percent, and values under 90 percent are considered low.</p> <p>- Patient #13's record included a physical therapy evaluation visit note, dated 11/24/14, and signed by the PT. The visit note documented an oxygen saturation level of 76% when using oxygen, it did not document how much oxygen was used. There was no documentation of communication with Patient #13's physician. Additionally, there was no documentation of communication with the</p>	G 144		

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G 144	<p>Continued From page 16 RN Case Manager.</p> <p>- Patient #13's record included a physical therapy visit note, dated 12/08/14, and signed by the PT. The note documented an oxygen saturation level of 71% while at rest, it did not document how much oxygen was used. Under the vital sign section it also documented Patient #13's oxygen saturation level was 79-95% while using 3.5 lpm of oxygen. There was no documentation of communication with Patient #13's physician. Additionally, there was no documentation of communication with the RN Case Manager.</p> <p>- Patient #13's record included a physical therapy visit note, dated 12/10/14, and signed by the Physical Therapist. The visit note documented 2 oxygen saturation levels. The first measurement was 82% with 2 lpm of oxygen. The second measurement was 91% with labored breathing. It was unclear if Patient #13 was using oxygen at the time of the second measurement. Additionally, there was no indication of time of the measurements or what his activity level was when the measurements were obtained. There was no documentation of communication with Patient #13's RN Case Manager.</p> <p>During an interview on 12/19/14 at 1:15 PM, the PT reviewed her notes and confirmed the oxygen saturation levels documented. She stated she did speak with the RN Case Manager about the low oxygen saturation levels, but it was not documented in the record. The PT stated she did not call Patient #13's physician to inform the physician of the low oxygen saturation levels.</p> <p>During an interview on 12/22/14 at 9:55 AM, the RN Case Manager reviewed the record. She</p>	G 144			

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G 144	<p>Continued From page 17</p> <p>confirmed she did speak with the PT and Patient #13's physician about the low oxygen saturation levels. The RN Case Manager confirmed these communications were not documented in the record.</p> <p>Coordination of care between PT and SN services was not documented in Patient #13's record.</p> <p>5. Patient #5 was an 83 year old male admitted to the agency on 11/19/14 for SN, PT, OT, and HHA services. Diagnoses included aphasia, abnormal gait, coronary atherosclerosis, anxiety, chronic pain, high blood pressure, and a pacemaker. Patient #5's record, including the POC, for the certification period 11/19/14 to 1/17/15, was reviewed.</p> <p>- The RN Case Manager documented visits to Patient #5 on 11/19/14, 11/21/14, 11/25/14, 12/04/14, and 12/11/14. The nursing visit notes, dated 11/21/14 and 11/25/14, documented the ST was contacted. There was no documentation of when the ST was contacted or what information was communicated.</p> <p>- Physical therapy visit notes were documented on 11/21/14 and 11/26/14. Both notes documented the RN was contacted. The 11/21/14 PT visit note did not include the date and time the RN was contacted. The 11/26/14 PT visit note did not include documentation of the date and time the RN was contacted or what was communicated.</p> <p>- In a physical therapy visit note, dated 11/26/14, the PTA documented Patient #5's blood pressure was 184/88 and 188/90, without receiving</p>	G 144			

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G 144	Continued From page 18 therapy. (The Mayo Clinic website, accessed 12/24/14, stated normal blood pressure levels range between 120-139 systolic [top number] and 80-89 diastolic [low number]). The PTA also documented she contacted the RN, who was going to contact the physician. However, there was no documentation in the record the RN Case Manager spoke with the PTA or the physician was contacted about Patient #5's high blood pressure. The RN Case Manager for Patient #5 was interviewed on 12/18/14 at 1:45 PM. The RN Case Manager stated the PTA did contact her about Patient #5's high blood pressure. She stated she contacted the physician and was told the physician wanted to keep Patient #5's blood pressure around 140. When asked about the diastolic reading, the RN Case Manager stated she did not recall what the physician indicated. She confirmed her communication with the PTA and physician was not documented. During an interview on 12/19/14 at 1:20 PM, the PT reviewed the physical therapy notes. She stated the PTA was no longer employed by the agency. The PT stated that communication occurs frequently between the RN Case Manager and other therapies but it was not documented in the records.	G 144			
G 155	Care coordination for Patient #5 was not documented. 484.16(a) ADVISORY AND EVALUATION FUNCTION The group of professional personnel's meetings are documented by dated minutes.	G 155			

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G 155	Continued From page 19 This STANDARD is not met as evidenced by: Based on review of the Professional Advisory Committee (PAC) quarterly evaluation minutes and staff interview, it was determined the PAC failed to document meetings with dated meeting minutes. This resulted in a lack of documented progress toward agency goals and actions taken. Findings include: A review of the PAC's quarterly meeting minutes dated 2014, revealed a list of the items below: Scope of services offered Admission and discharge policy Plan of Care POC (plan of care) Emergency care Clinical records Personnel qualifications Program evaluation Review of by-laws Budget and capitalization review The PAC did not maintain meeting minutes to document what was discussed, and action taken, related to the listed items. During an interview with the Administrator on 12/19/14 beginning at 9:00 AM, he verified the PAC did not have meeting minutes, only the list of topics. The Governing Body did not ensure PAC meeting minutes were maintained.	G 155	New PAC Meeting format created with all information and comment period to be sent to members of governing body. Used regulation IDAPA 16.03.07 to develop format. Accurate record keeping and minutes to be taken at meeting. Also, please note Agency Evaluation, QI, Policy and Procedure review, and Agency Operations report added to meeting agenda. PAC Meeting to occur on Feb. 3rd, 2015. Governing Body Meetings to be held in conjunction with PAC Meetings Please see attachments: 10.11.12.13.14.15.16.51.52	2/4/15
G 156	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 156	Proper PAC protocol, consistent chart audits, performance tracking, QI, and agency evaluations will improve overall delivery of care and allow for better measurement and care standards. Consistent record keeping and storage will also help to improve year over year comparisons. Ultimately resulting in improved quality of care.	

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G 156	Continued From page 20 This CONDITION is not met as evidenced by: Based on observation, medical record review, policy review, observations during home visits and patient and staff interview, it was determined the agency failed to ensure care was provided in accordance with patients' POCs, that the POCs included all pertinent information, and the physician was notified if the POCs were altered or patients' conditions changed. This resulted in unmet patient needs, negative patient outcomes, and care provided without physician authorization. Findings include: 1. Refer to G158 as it relates to the failure of the agency to notify physicians when the POC for patients was altered by missed visits or not otherwise followed. 2. Refer to G159 as it relates to the failure of the agency to ensure all pertinent information was included in patients' POCs. 3. Refer to G160 as it relates to the failure of the agency to consult the physician to approve the POC. 4. Refer to G164 as it relates to the failure of the agency to notify the physician with changes in patients' conditions. The cumulative effect of these negative systemic practices impeded the ability of the agency to provide care of sufficient scope and quality.	G 156	Person Responsible: Home Health Director Multiple changes to process, documentation, and communication made. Please see changes next to corresponding G tags:	
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER	G 158		

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G 158	<p>Continued From page 21</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, staff interview, and observations, it was determined the agency failed to ensure care followed the physician's written plan of care for 6 of 13 patients (#1, #3, #4, #8, #10, and #13) whose records were reviewed. This resulted in unauthorized treatments as well as omissions of care and had the potential to result in unmet patient needs. Findings include:</p> <p>1. Patient #1 was an 86 year old female admitted to the agency on 10/27/14, for SN and PT services. Diagnoses included left ankle wound, abnormal gait, post-traumatic wound infection, muscle weakness, and history of fall. Patient #1's record including the POC, for the certification period 10/027/14 to 12/25/14, was reviewed.</p> <p>Patient #1's record contained a request, dated 10/30/14, from the RN Case Manager for a referral to a wound clinic. The request was signed by the attending physician on 11/13/14. There was no documentation by the attending physician that wound clinic orders may be followed for Patient #1's wound care.</p> <p>RN Case Manager visit notes dated 11/10/14, 11/12/14, 11/14/14, 11/17/14, 11/19/14, 11/24/14, 11/26/14, 12/01/14, 12/03/14, 12/08/14, 12/10/14, and 12/12/14 documented wound care interventions that were not ordered on the POC. However, the Interventions documented wound care that followed orders, dated 11/07/14, 11/21/14, and 12/05/14, from the wound clinic</p>	G 158	<p>Inservice given to instruct clinicians on adequate notification to changes in POC and following MD orders. Inservice given to nursing on appropriate wound order management as well as WOCN guidelines. Touchmark policy reviewed to refresh nursing staff. See attachments: 21,22,23,24,25,26,27,28,29</p> <p>Thorough communication and documentation improvements will help maximize care efficiency and create a better plan of care for patients. Establishing effective communication avenues leads to better understanding of patient conditions and status changes. It also helps to recognize improvements or declines quicker for faster intervention management.</p>	1/21/15	

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G 158	<p>Continued From page 22 and signed by the wound clinic physician.</p> <p>During an interview on 12/18/14 at 9:55 AM, the RN Case Manager confirmed she was following the orders from the wound clinic. She also confirmed there was not an order from the Patient #1's attending physician that the agency could follow orders written by the physician at the wound clinic.</p> <p>Patient #1's wound care was not provided as ordered by her physician on the POC.</p> <p>2. Patient #3 was a 96 year old female admitted to the agency on 10/16/14, for SN, PT, and HHA services. Diagnoses included rehabilitation services, muscle weakness, abnormal gait, atrial fibrillation, high blood pressure, history of fall, and stroke. Patient #3's record, including the POC, for the certification period 10/16/14 to 12/14/14, was reviewed.</p> <p>Patient #3 was admitted to the hospital during her certification period on 10/28/14. On 11/04/14, the RN documented a resumption of care visit. The POC at resumption of care included orders to review blood sugars every visit and instruct patient/caregiver about signs and symptoms of hypo/hyperglycemia, nutrition, and diabetic foot care. The RN Case Manager did not document blood sugars or teaching about diabetic foot care on her visit notes, dated 11/04/14, 11/06/14, 11/11/14, 11/25/14, and 12/02/14.</p> <p>During an interview on 12/18/14 at 11:45 AM, the RN Case Manager reviewed Patient #3's record and confirmed no blood sugar levels were documented. She stated Patient #3's son was her primary caregiver. He would not check the</p>	G 158	<p>Instruction on patient parameters and better follow through of physician orders will assist care delivery as ordered and expected. Education and reminder to clinicians to consistently check and follow physician orders will also solidify proper process and care delivery as ordered. Proper wound care management will decrease infection risk and improve patient outcomes. Thorough wound documentation and wound management will also facilitate and coordinate efforts with multiple physicians, wound clinic, etc. to keep all parties apprised of patient wound status and healing potentials. Will be monitored by Clinical Supervisor during review of Oasis completion and patient notes.</p> <p>Persons Responsible: Clinical Supervisor</p>	

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G 158	<p>Continued From page 23</p> <p>blood sugar levels because he stated it was controlled by her diet. The RN Case Manager confirmed that she did not inform the physician that blood sugar levels are not being monitored. She also confirmed diabetic foot care education was not documented in her visit notes.</p> <p>Patient #3's did not receive blood sugar monitoring and diabetic foot care education as ordered on her POC.</p> <p>3. Patient #10 was a 71 year old female admitted to the agency on 11/14/14, for SN, PT, and OT services. Diagnoses included pneumonitis due to inhalation of vomitus or food, multiple sclerosis, chronic pain, depression, and Intestinal infection. Patient #10's record, including the POC, for the period 11/14/14 to 1/12/15, was reviewed.</p> <p>Patient #10's POC included orders for the SN to instruct Patient #10 on daily self catheterization. The orders also included instructing Patient #10 about signs and symptoms of a urinary tract infection and catheter care. The RN Case Manager made visits dated 11/14/14, 11/17/14, 11/19/14, 11/21/14, 11/24/14, 12/03/14, 12/05/14, 12/09/14, 12/12/14, and 12/15/14. The 10 visit notes did not include documentation of teaching or instructing Patient #10 about self catheterization, catheter care, or signs and symptoms of urinary tract infections.</p> <p>During an interview on 12/17/14 at 9:15 AM, the RN Case Manager confirmed Patient #10 self catheterized daily and has been doing this for many years. She stated there was no teaching or education done because Patient #10 Informed the RN Case Manager she was comfortable with using a catheter. The RN Case Manager stated</p>	G 158			

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G 158	<p>Continued From page 24 she was not aware of the order on the POC.</p> <p>Patient #10 did not receive instruction on self catheterization and catheter care as ordered on her POC.</p> <p>4. Patient #13 was a 91 year old male admitted to the agency on 11/13/14 for SN and PT services. Diagnoses included gallstones, coronary atherosclerosis, diabetes mellitus, pulmonary fibrosis, depression, B-complex deficiencies, and supplemental oxygen. Patient #13's record, including the POC, for the period 11/13/14 to 1/11/15, was reviewed.</p> <p>Patient #13's POC included orders for the SN to instruct Patient #13 on signs and symptoms of hypo/hyperglycemia, proper diabetic foot care, and monitoring of blood sugar levels. The POC also included orders to instruct Patient #13 to keep a daily blood sugar log and to review the log with each SN visit. The RN Case Manager made 4 visits dated 11/13/14, 11/17/14, 12/08/14, and 12/17/14. The visit notes did not include documentation of blood sugar levels or teaching Patient #13 about diabetic nutrition or foot care.</p> <p>During an interview on 12/22/14 at 9:55 AM, the RN Case Manager reviewed the record and confirmed no blood sugar levels were documented in Patient #13's SN visit notes. She stated he refused to check his blood sugar and the physician was aware. The RN Case Manager confirmed this information was not documented in Patient #13's record. She also confirmed diabetic teaching was not documented on her visit notes.</p> <p>Patient #13's POC was not followed for diabetic monitoring and teaching as ordered by his</p>	G 158			

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G 158	<p>Continued From page 25 physician.</p> <p>5. Patient #8 was a 71 year old male admitted to the agency on 10/19/14, for treatment of decubitus ulcers. Additional diagnoses included non-surgical wound dressing changes, diabetes type II, long-term insulin use, and dementia. He received SN and PT services. His record, including the POC, for the certification period 10/19/14 to 12/17/14, was reviewed.</p> <p>Patient #8's POC included orders for SN to monitor blood glucose levels at every visit.</p> <p>SN notes, dated 11/03/14, 11/07/14, 11/11/14, 11/12/14, 11/17/14, and 12/01/14, did not include assessment of blood glucose levels as ordered.</p> <p>The RN Case Manager was interviewed on 12/17/14 beginning at 12:00 PM. She confirmed blood glucose levels were not documented on 11/03/14, 11/07/14, 11/11/14, 11/12/14, 11/17/14, and 12/01/14.</p> <p>Patient #8's SN notes did not include assessments of blood glucose levels as ordered in his POC.</p> <p>6. Patient #4 was a 92 year old female admitted to the agency on 12/02/14, for diarrhea. Additional diagnoses included congestive heart failure, hypertension, kidney disease, diabetes type II, dementia, atrial fibrillation, and osteoarthritis. She received SN, PT, and OT services. Her record, including the POC, for the certification period 12/02/14 to 1/30/15, was reviewed.</p>	G 158			

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G 158	Continued From page 26 Patient #4's POC included orders for SN to monitor blood glucose levels at every visit. SN notes, dated 12/02/14 and 12/09/14 did not include assessment of blood glucose levels as ordered. The RN Case Manager was interviewed on 12/17/14 beginning at 12:00 PM. She confirmed blood glucose levels were not documented on SN visit notes dated 12/02/14 and 12/09/14. Patient #4's SN notes did not include assessments of blood glucose levels as ordered in her POC.	G 158		
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure patients' POCs included all pertinent information for 4 of 13 patients (#1, #5, #8, and #11) whose records were reviewed. This had the potential to interfere with continuity and completeness of patient care. Findings include:	G 159	Inservice given to staff on POC development, coordination, and adherence. Discussed all aspects of plan of care, and to utilize all resources available to best construct most beneficial plan to care for patient. Inserviced staff on proper coordination of POC and need to notify physician and all others involved for any change to POC. Will document all coordination on new coordination form implemented due to this survey.	1/15/15

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G 159	<p>Continued From page 27</p> <p>1. Patient #11 was an 87 year old male admitted to the agency on 11/08/14, for wound care of a decubitus ulcer stage IV. Additional diagnoses included after care of healing hip fracture, CAD, paralysis agitans, acute poliomyelitis, adjustment of urinary device, change or removal of non-surgical wound dressing and post-surgical aortocoronary bypass. He received SN, PT and OT services. His record, including the POC, for the certification period 11/08/14 to 1/06/15, was reviewed.</p> <p>Patient #11's SN SOC assessment visit, dated 11/08/14, included three wounds assessed: #1 right buttock, #2 left bicep, and #3 left upper quadrante of the abdomen (PEG tube removal site). The POC included an order for the SN to check skin integrity every visit, perform wound care to right buttocks, and to treat multiple lacerations to bilateral upper extremities. However, it did not include interventions for wound number 3, located at the left upper quadrante of the abdomen.</p> <p>During an interview on 12/18/14 at 11:45 AM, the RN who completed Patient #11's SOC assessment confirmed the POC did not include orders for wound care to the left upper quadrante of the abdomen.</p> <p>Patient #11's POC did not include interventions for wound care or management of his abdominal wound.</p> <p>2. Patient #8 was a 71 year old male admitted to the agency on 10/19/14, for SN and, PT services related to decubitus ulcer. Additional diagnoses included pressure ulcer stage III, diabetes type II, long term use of insulin, and dementia. His</p>	G 159	<p>Continued</p> <p>In-service given to clinicians on following POC. Topics included but are not limited to: Adherence, Correct Interventions and treatments, Care Coordination, and physician notification. Inservice given to staff on establishing, maintaining, reporting and coordination of patient parameters. See attachments: 21,22,23,24,25,26</p>	

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G 159	<p>Continued From page 28 record, including the POC, for the certification period of 10/19/14 to 12/17/14, was reviewed.</p> <p>During a home visit on 12/15/14 beginning at 1:00 PM, it was observed that Patient #8's left dorsal foot had a new wound.</p> <p>An SN visit note, dated 12/15/14 at 12:50 PM, documented a new area of concern on the left dorsal for a small opened wound.</p> <p>The RN Case Manager was interviewed on 12/17/14 at 12:00 PM. She confirmed, Patient #8 had a new wound on his left dorsal foot. The RN Case Manager confirmed Patient #8's new wound on his left dorsal foot was not communicated to his physician, and the POC was not ammended.</p> <p>Patient #8's POC was not updated to include interventions to manage the care of the new wound.</p> <p>3. Patient #1 was an 86 year old female admitted to the agency on 10/27/14, for SN and PT services. Diagnoses included left ankle wound, abnormal gait, post-traumatic wound infection, muscle weakness, and history of fall. Patient #1's record including the POC, for the certification period 10/27/14 to 12/25/14, was reviewed.</p> <p>Patient #1's record contained an admission assessment dated 10/27/14, and signed by the RN Case Manager. The form documented Patient #1 was assessed to be at risk for depression, with interventions to be provided by SN services. The interventions were to observe for signs and symptoms of depression, assess effectiveness of medication, and assess for the need of an evaluation by the primary physician.</p>	G 159	<p>Increased understanding and improved POC creation will lead to more focused and improved treatment and modalities as well as enhance overall patient care. Inservice proved worthy to staff to remember that a POC is more than just a tangible piece of paper but an overall plan to treat patients and improve their condition. It requires critical thinking and updates as well as overall perspective of patient status.</p> <p>There was also an increased understanding created of need to communicate and coordinate in all aspects in POC management. When reviewing the survey findings with staff there was a clarity in expectation and concept of what a POC should look like and contain to improve patient outcomes and quality of care.</p>		

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G 159	<p>Continued From page 29</p> <p>The form also stated the orders and interventions identified will be included on the POC.</p> <p>The POC, signed by the RN Case Manager, did not include orders for assessment and observation of depression signs and symptoms.</p> <p>During an interview on 12/18/14 at 9:55 AM, the RN Case Manager who completed the admission assessment, confirmed the POC did not include orders to assess or observe for depression.</p> <p>Patient #1's POC did not include interventions for depression assessment or management.</p> <p>4. Patient #5 was an 83 year old male admitted to the agency on 11/19/14, for SN, PT, OT, and HHA services. Diagnoses included aphasia, abnormal gait, coronary atherosclerosis, anxiety, chronic pain, high blood pressure, and a pacemaker. Patient #5's record, including the POC, for the certification period 11/19/14 to 1/17/15, was reviewed.</p> <p>- Patient #5's home health medical record included a copy of a History and Physical (H&P) assessment from his hospitalization on 9/23/14. It was faxed to the agency on 11/17/14, from the SNF Patient #5 was discharged from on 11/18/14. The Past Surgical History section of the hospital H&P assessment stated Patient #5 had previously undergone a right knee replacement. However, his right knee replacement was not noted in Patient #5's SOC comprehensive assessment, completed on 11/19/14, or his POC.</p> <p>The RN Case Manager who completed the "Musculoskeletal" section of the SOC comprehensive assessment, was interviewed on</p>	G 159	<p>Continued:</p> <p>Instruction on patient parameters and focused follow through of physician orders will enhance care delivery as ordered and expected. Education and reminder to clinicians to consistently check and follow physician orders will also solidify proper process and care delivery as ordered. Will be monitored by Clinical Supervisor during review of Oasis completion and patient notes.</p> <p>Persons Responsible: Clinical Supervisor,</p>	

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G 159	Continued From page 30 12/18/14 starting at 1:45 PM. She confirmed the right knee replacement was not included in the SOC assessment and POC. - The 9/23/14 hospital H&P assessment stated Patient #5 was allergic to penicillin, contrast dye, shellfish, and morphine. Patient #5's home health record included a copy of a 10/02/14 SNF Admission Record, faxed to the agency from the SNF on 11/17/14. The SNF Admission Record indicated Patient #5 was also allergic to iodine. Patient #5's POC listed Patient #5's allergies as penicillin and seafood. Patient #5's POC did not include his allergies to contrast dye, morphine, and iodine. Additionally, it did not state that his seafood allergy was specific to shellfish. During an interview on 12/19/14 at 1:20 PM, the PT that completed the allergy section of Patient #5's SOC comprehensive assessment confirmed the allergy discrepancies. - The "Therapy Need and Plan of Care" section of Patient #5's 11/19/14 SOC comprehensive assessment indicated parameters were required for his "vital signs or other clinical findings." However, Patient #5's POC did not include specific parameters. The PT that completed the "Therapy Need and Plan of Care" section of Patient #5's SOC comprehensive assessment was interviewed on 12/19/14 at 1:20 PM. She stated she may have made an error, but was not certain. Patient #5's POC did not include all pertinent information.	G 159			
G 160	484.18(a) PLAN OF CARE	G 160			

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G 160	Continued From page 31 If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan. This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure a physician was consulted to approve the POC for 3 of 13 patients (#1, #5, and #13) whose records were reviewed. This resulted in plans of care that were developed and initiated without appropriate physician approval. Findings include: The agency policy, number 10.1 "Therapy Policies" dated 6/21/05, stated the therapist may make an initial visit, with the physician's order, to evaluate a client prior to securing specific written orders. The therapist shall participate with the agency staff in implementing the physician POC, in scheduling visits, and in evaluating client care. 1. Patient #1 was an 86 year old female admitted to the agency on 10/27/14 for SN and PT services. Diagnoses included left ankle wound, abnormal gait, post-traumatic wound infection, muscle weakness, and history of fall. Patient #1's record including the POC, for the certification period 10/27/14 to 12/25/14, was reviewed. Patient #1's record included a physical therapy evaluation visit note, dated 11/06/14, and signed by the PT. Patient #1's record did not include documentation the Physical Therapist contacted the physician to for verbal approval of the POC prior to initiation of ongoing services. Patient #1's physician signed the physical therapy POC on	G 160	Inserviced staff and Clinical Supervisor on importance and necessity of receiving verbal SOC orders, that include modalities, on all new starts or changes to POC before subsequent visits are made. See Attachments: 21,22,23,24,25,26 All staff have increased understanding of following physician orders and importance of obtaining verbal orders before written ones are received. Will be monitored by Clinical Supervisor during review of Oasis completion and patient notes.	1/21/15

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G 160	<p>Continued From page 32 11/18/14.</p> <p>Patient #1's record included physical therapy visit notes dated 11/11/14 and 11/13/14, and signed by the PT. However, her POC was not signed by Patient #1's physician until 11/18/14.</p> <p>During an interview on 12/18/14 at 9:55 AM, the Clinical Director reviewed Patient #1's record and confirmed the physical therapy POC was not approved by her physician prior to the PT visits on 11/11/14 and 11/13/14.</p> <p>PT visits were provided to Patient #1 prior to physician approval of the physical therapy POC.</p> <p>2. Patient #5 was an 83 year old male admitted to the agency on 11/19/14 for SN, PT, OT, and HHA services. Diagnoses included aphasia, abnormal gait, coronary atherosclerosis, anxiety, chronic pain, high blood pressure, and a pacemaker. Patient #5's record, including the POC, for the certification period 11/19/14 to 1/17/15, was reviewed.</p> <p>Patient #5's record included a physical therapy SOC visit note, dated 11/19/14, and signed by the PT. Patient #5's record did not include documentation the PT contacted the physician to receive verbal approval of the POC and initiation of ongoing services. Patient #5's physician had not signed the POC as of 12/22/14.</p> <p>Patient #5's record included physical therapy visit notes dated 11/21/14, 11/26/14, 12/02/14, and 12/12/14, and signed by the PT. However, his POC was not signed as of 12/22/14.</p> <p>During an interview on 12/19/14 at 1:20 PM, the</p>	G 160	<div style="border: 1px solid black; padding: 5px;"> <p>Persons Responsible: Clinical Supervisor</p> </div>	

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G 160	<p>Continued From page 33</p> <p>PT reviewed the record and confirmed the POC was not signed. She stated after she makes an evaluation visit she gives the physical therapy POC to the Clinical Director to fax or phone the attending physician for approval. The PT stated she did not routinely contact the physician for verbal approval of physical therapy POC's.</p> <p>Physical therapy visits were provided to Patient #5 prior to physician approval of the POC.</p> <p>3. Patient #13 was a 91 year old male admitted to the agency on 11/13/14 for SN and PT services. Diagnoses included gallstones, coronary atherosclerosis, diabetes mellitus, pulmonary fibrosis, depression, B-complex deficiencies, and supplemental oxygen. Patient #13's record, including the POC, for the certification period 11/13/14 to 1/11/15, was reviewed.</p> <p>Patient #13's record included a physical therapy evaluation visit note, dated 11/14/14, and signed by the PT. Patient #13's record did not include documentation the Physical Therapist contacted the physician to receive verbal approval of the POC and initiation of ongoing services. Patient #13's physician was contacted by the Clinical Director and given verbal approval for the physical therapy POC on 11/24/14.</p> <p>Patient #13's record included physical therapy visit notes dated 11/18/14 and 11/20/14, and signed by the PT. However, the POC was not signed by Patient #1's physician until 11/18/14.</p> <p>During an interview on 12/19/14 at 1:15 PM, the PT reviewed the record and confirmed the physical therapy POC was not signed by the physician. She confirmed the Clinical Director</p>	G 160			

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G 160	Continued From page 34 contacted Patient #13's physician, on 11/24/14, by phone. She stated after she makes an evaluation visit she gives the physical therapy POC to the Clinical Director to fax or phone the attending physician for approval. The PT stated she did not routinely contact the physician for verbal approval of therapy POC's.	G 160		
G 164	PT visits were provided to Patient #13 prior to physician approval of the physical therapy POC. 484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on review of patient records, patient documentation, and staff interview, it was determined the agency failed to ensure professional staff promptly alerted the physician to changes in patients' conditions that suggested a need to alter the POC for 5 of 13 patients (#5, #8, #10, #11, and #1) whose records were reviewed. As a result, physicians were precluded from making changes in patients' POCs to ensure their needs were met. Findings include: 1. Patient #8 was a 71 year old male admitted to the agency on 10/19/14, for SN and, PT services related to decubitus ulcer. Additional diagnoses included pressure ulcer stage III, diabetes type II, long term use of insulin, and dementia. His record, including the POC, for the certification period of 10/19/14 to 12/17/14, was reviewed.	G 164	Inservice given to staff to discuss and educate on importance of communication and reporting to physician for any change in patient condition, change to POC, status change, etc. included importance of proper and complete documentation and gathering of orders for any change to POC. In-service given to nursing on appropriate wound order management. Please see attachments: 21,22,23,24,25,26,27,28,29	1/21/15

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G 164	<p>Continued From page 36</p> <p>During a home visit on 12/15/14 beginning at 1:00 PM, it was observed that Patient #8's left dorsal foot had a new wound. The SN cleaned the wound, applied a topical antibiotic, and a gauze dressing.</p> <p>An SN visit note, dated 12/15/14 at 12:50 PM, documented a new area of concern on the left dorsal foot for a small opened wound.</p> <p>The RN Case Manager was interviewed on 12/17/14 at 12:00 PM. She confirmed, Patient #8 had a new wound on his left dorsal foot. The RN Case Manager confirmed Patient #8's new wound on his left dorsal foot was not communicated to his physician, and wound care orders were not obtained.</p> <p>Patient #8's new wound was not communicated to his physician.</p> <p>2. Patient #11 was an 87 year old male admitted to the agency on 11/08/14, for wound care of decubitus ulcer stage IV. Additional diagnoses included after care of healing hip fracture, CAD, paralysis agitans, acute poliomyelitis, adjustment of urinary device, change or removal of non-surgical wound dressing and post-surgical aortocoronary bypass. He received SN, PT and OT services. His record, including the POC, for the certification period 11/08/14 to 1/06/15, was reviewed.</p> <p>Patient #11's SN SOC assessment visit on 11/08/14, documented three wounds, #1 right buttock, #2 left biceps, and #3 left upper quadrante of the abdomen. The POC included an order for the SN to perform a skin integrity assessment</p>	G 164	<p>Increased understanding and improved POC creation will lead to more focused and improved treatment and modalities as well as better overall patient care. In-service proved worthy to staff to remember that a POC is more than just a tangible piece of paper but an overall plan to treat patients and improve their condition. It requires critical thinking and updates as well as overall perspective of patient status. There was also a better understanding created of need to communicate and coordinate in all aspects in POC management. When reviewing the survey findings with staff there was a clarity in expectation and concept of what a POC should look like and contain to improve patient outcomes and quality of care. Instruction on patient parameters and better follow through of physician orders will facilitate care delivery as ordered and expected. Education and reminder to clinicians to consistently check and follow physician orders will also solidify proper process and care delivery as ordered.</p>	

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G 164	<p>Continued From page 36</p> <p>every visit, perform wound care to right buttocks and to treat multiple lacerations to bilateral upper extremity. It did not include interventions for wound number 3.</p> <p>During an interview on 12/18/14 at 11:45 AM, the RN who completed Patient #11's SOC assessment confirmed the POC did not include orders for wound care to the left upper quadrante of the abdomen.</p> <p>Patient #11's POC did not include wound care orders for all of his wounds.</p> <p>3. Patient #5 was an 83 year old male admitted to the agency on 11/19/14 for SN, PT, OT, and HHA services. Diagnoses included aphasia, abnormal gait, coronary atherosclerosis, anxiety, chronic pain, high blood pressure, and a pacemaker. Patient #5's record, including the POC, for the certification period 11/19/14 to 1/17/15, was reviewed.</p> <p>In a physical therapy visit note, dated 11/26/14, the PTA documented Patient #5's blood pressure was 184/88 and 188/90, without receiving therapy. (The Mayo Clinic website, accessed 12/24/14, stated normal blood pressure levels range between 120-139 systolic [top number] and 80-89 diastolic [low number]). The PTA documented she contacted the RN, and the RN stated she would contact the physician. However, there was no documentation by the RN Case Manager that she spoke with the PTA, or the physician was contacted about Patient #5's blood pressure.</p> <p>During an interview on 12/19/14 at 1:20 PM, the</p>	G 164	<div style="border: 1px solid black; padding: 5px;"> <p>Responsible Persons: Clinical Supervisor Will be monitored by Clinical Supervisor during review of Oasis completion and patient notes.</p> </div>		

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G 164	<p>Continued From page 37</p> <p>PT reviewed the physical therapy notes. She stated the PTA was no longer employed by the agency. The PT stated that communication occurred frequently between the RN Case Manager and other therapies but it was not documented in the records.</p> <p>The RN Case Manager for Patient #5 was interviewed on 12/18/14 at 1:45 PM. The RN Case Manager stated the PTA did contact her about Patient #5's high blood pressure. She stated she contacted the physician and was told the physician wanted to keep Patient #5's blood pressure around 140. When asked about the diastolic reading, the RN Case Manager stated she did not recall what the physician indicated. She confirmed Patient #5's POC was not updated to include specific blood pressure parameters to alert staff, and the patient and his spouse, when to notify his physician of high blood pressure readings.</p> <p>Patient #5's POC was not updated to meet his needs.</p> <p>4. Patient #10 was a 71 year old female admitted to the agency on 11/14/14 for SN, PT, and OT services. Diagnoses included pneumonitis due to inhalation of vomitus or food, multiple sclerosis, chronic pain, depression, and intestinal infection. Patient #10's record, including the POC, for the certification period 11/14/14 to 1/12/15, was reviewed.</p> <p>An SN visit note, dated 12/03/14, and signed by the RN Case Manager, documented Patient #10 fell one week prior and sprained her left ankle. There was no documentation the physician was contacted about Patient #10's fall and subsequent</p>	G 164			

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G 164	<p>Continued From page 38 injury.</p> <p>The RN Case Manager documented Patient #10's left ankle was swollen and painful, and encouraged her to follow up with a physician. The RN Case Manager documented Patient #10 stated she would make an appointment to have her ankle examined.</p> <p>During an interview on 12/17/14 at 9:15 AM, the RN Case Manager reviewed her note on 12/03/14 and confirmed the physician was not informed of the fall or injury. She stated Patient #10 told her she was going to make an appointment to follow up with the physician about her injured ankle. The RN Case Manager confirmed she did not follow up with Patient #10 to ensure she made an appointment.</p> <p>Patient #10's injury and falls were not communicated to her physician.</p> <p>5. Patient #13 was a 91 year old male admitted to the agency on 11/13/14 for SN and PT services. Diagnoses included gallstones, coronary atherosclerosis, diabetes mellitus, pulmonary fibrosis, depression, B-complex deficiencies, and supplemental oxygen. Patient #13's record, including the POC, for the certification period 11/13/14 to 1/11/15, was reviewed.</p> <p>Patient #13's POC ordered oxygen at 2 lpm at rest and 4 lpm with exertion. The Mayo Clinic website, accessed on 12/24/14, stated normal oxygen saturation levels range from 95 to 100 percent, and values under 90 percent are considered low.</p> <p>- Patient #13's record included a physical therapy</p>	G 164			

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G 164	<p>Continued From page 39</p> <p>visit note, dated 11/24/14, and signed by the Physical Therapist. The visit note documented an oxygen saturation level of 76% when using oxygen. It did not document how much oxygen was used. There was no documentation of communication with Patient #13's physician.</p> <p>- Patient #13's record included a physical therapy visit note, dated 12/08/14, and signed by the Physical Therapist. The visit note documented an oxygen saturation level of 71% while at rest. It did not document how much oxygen was used. Under the vital sign section it also documented Patient #13's oxygen saturation level was 79-95% while using 3.5 lpm of oxygen. There was no documentation of communication with Patient #13's physician.</p> <p>- Patient #13's record included a physical therapy visit note, dated 12/10/14, and signed by the Physical Therapist. The visit note documented 2 oxygen saturation levels. The first measurement was 82% with 2 lpm of oxygen. The second measurement was 91% with labored breathing. It was unclear if Patient #13 was using oxygen at the time of the second measurement. Additionally, there was no indication of time of the measurements or what his activity level was when the measurements were obtained. There was no documentation of communication with Patient #13's physician.</p> <p>During an interview on 12/19/14 at 1:15 PM, the PT reviewed her notes and confirmed the oxygen saturation levels documented. She stated she did speak with the RN Case Manager about the low oxygen saturation levels, but it was not documented in the record. The PT stated she did not call the physician and inform them of the low</p>	G 164			

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G 164	Continued From page 40 oxygen saturation levels. During an interview on 12/22/14 at 9:55 AM, the RN Case Manager reviewed the record. She confirmed she did speak with the PT about the low oxygen saturation levels. The RN Case Manager stated she did speak with the PT and Patient #13's physician regarding his blood pressure. However, there was no documentation to verify the contact, the date it occurred or what was communicated.	G 164			
G 168	Patient #13's physician was not informed of his low oxygen saturation levels. 484.30 SKILLED NURSING SERVICES This CONDITION is not met as evidenced by: Based on review of clinical records and patient documentation, observation during home visits, policy review, and patient/family member and staff interview, it was determined the HHA failed to ensure skilled nursing services necessary to meet the health and safety needs of patients were implemented in accordance with patients' POCs. This negatively impacted quality, coordination, and safety of patient care. Findings include: 1. Refer to G170 as it relates to the failure of the agency to ensure the RN implemented care in accordance with POCs. 2. Refer to G171 as it relates to the failure of the agency to ensure the RN made the initial evaluation visit.	G 168	Multiple corrections made to skilled nursing services. Corrections listed next to corresponding G tags:		

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G 168	Continued From page 41 3. Refer to G173 as it relates to the agency's failure to ensure that nursing staff completed a thorough and accurate assessment, and initiated a POC that met all of the patient's needs. 4. Refer to G337 as it relates to the failure of the agency to ensure the comprehensive assessment completed by the RN included a medication review to obtain a current list of patient medications, evaluation of drug interactions, identification of possible significant side effects or noncompliance, and reconciliation of the medications with the physician. These failures created the imminent potential for a patient to sustain serious injury, harm, or death. The cumulative effect of these negative systemic practices seriously impeded the ability of the agency provide care of sufficient scope and quality.	G 168			
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on staff interview, observation, and review of medical records, it was determined the agency failed to ensure SN services were provided in accordance with POCs for 6 of 12 patients (#1, #3, #4, #8, #10, and #13), who received SN care and whose records were reviewed. This resulted in inadequate patient care and had the potential for negative patient outcomes. Findings include: 1. Patient #8 was a 71 year old male admitted to the agency on 10/19/14, for treatment of	G 170	Inservice given to staff on POC development, coordination, and adherence. Discussed all aspects of plan of care, and to utilize all resources available to best construct most beneficial plan to care for patient. Inservice staff on proper coordination of POC and need to notify physician and all others involved for any change to POC. Will document all coordination on new coordination form implemented due to this survey.	1/15/15	

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G 170	<p>Continued From page 42</p> <p>decubitus ulcers. Additional diagnoses included non-surgical wound dressing changes, diabetes type II, long-term insulin use, and dementia. He received SN and PT services. His record, including the POC, for the certification period 10/19/14 to 12/17/14, was reviewed.</p> <p>Patient #8's POC included orders for an SN to monitor blood glucose levels at every visit.</p> <p>SN notes, dated 11/03/14, 11/07/14, 11/11/14, 11/12/14, 11/17/14, and 12/01/14, and signed by the RN Case Manager did not include assessment of blood glucose levels as ordered.</p> <p>The RN Case Manager was interviewed on 12/17/14 beginning at 12:00 PM. She confirmed SN assessments of blood glucose levels were not documented on 11/03/14, 11/07/14, 11/11/14, 11/12/14, 11/17/14, and 12/01/14.</p> <p>Patient #8's POC was not followed for blood glucose monitoring as ordered by the physician.</p> <p>2. Patient #4 was a 92 year old female admitted to the agency on 12/02/14, for diarrhea. Additional diagnoses included congestive heart failure, hypertension, kidney disease, diabetes type II, dementia, atrial fibrillation, and osteoarthritis. She received SN, PT, and OT services. Her record, including the POC, for the certification period 12/02/14 to 1/30/15, was reviewed.</p> <p>Patient #4's POC included orders for SN to monitor blood glucose levels at every visit.</p> <p>SN notes, dated 12/02/14, and 12/09/14, and signed by the RN Case Manager, did not include</p>	G 170	<p>Cont.</p> <p>In-service given to clinicians on following POC. Topics included but are not limited to: Adherence, Correct interventions and treatments, care coordination, and physician notification. Inservice given to staff on establishing, maintaining, reporting and coordination of patient parameters. See attachments: 21,22,23,24,25,26</p>	

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G 170	<p>Continued From page 43 assessment of blood glucose levels as ordered.</p> <p>The RN Case Manager was interviewed on 12/17/14 beginning at 12:00 PM. She confirmed SN assessments of blood glucose levels were not documented on 12/02/14 and 12/09/14.</p> <p>Patient #4's POC was not followed for blood glucose monitoring as ordered by the physician.</p> <p>3. Patient #1 was an 86 year old female admitted to the agency on 10/27/14, for SN and PT services. Diagnoses included left ankle wound, abnormal gait, post-traumatic wound infection, muscle weakness, and history of fall. Patient #1's record, including the POC, for the certification period 10/027/14 to 12/25/14, was reviewed.</p> <p>Patient #1's record contained a request, dated 10/30/14, from the RN Case Manager for a referral to a wound clinic. The request was signed by the attending physician on 11/13/14. There was no documentation by the attending physician that the agency could follow orders written by the physician at the wound care clinic.</p> <p>Visit notes dated 11/10/14, 11/12/14, 11/14/14, 11/17/14, 11/19/14, 11/24/14, 11/26/14, 12/01/14, 12/03/14, 12/08/14, 12/10/14, and 12/12/14, and signed by the RN Case Manager, documented wound care interventions that were not ordered on the POC. However, the interventions documented followed wound care orders, dated 11/07/14, 11/21/14, and 12/05/14, from the wound clinic and signed by the wound clinic physician.</p> <p>During an interview on 12/18/14 at 9:55 AM, the RN Case Manager confirmed she was following</p>	G 170	<div style="border: 1px solid black; padding: 5px;"> <p>Improved understanding and improved POC creation will lead to more focused and improved treatment and modalities as well as enhanced overall patient care. inservice proved worthy to staff to remember that a POC is more than just a tangible piece of paper but an overall plan to treat patients and improve their condition. It requires critical thinking and updates as well as overall perspective of patient status.</p> <p>There was also an increased understanding created of need to communicate and coordinate in all aspects in POC management. When reviewing the survey findings with staff there was a clarity in expectation and concept of what a POC should look like and contain to improve patient outcomes and quality of care.</p> </div>	

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G 170	<p>Continued From page 44</p> <p>the orders from the wound care clinic. She also confirmed there was not an order from the attending physician that the wound clinic physician may write orders for Patient #1.</p> <p>Patient #1's POC was not followed for wound care treatment as ordered by her attending physician.</p> <p>4. Patient #3 was a 96 year old female admitted to the agency on 10/16/14, for SN, PT, and HHA services. Diagnoses included rehabilitation services, muscle weakness, abnormal gait, atrial fibrillation, high blood pressure, history of fall, and stroke. Patient #3's record, including the POC, for the certification period 10/16/14 to 12/14/14, was reviewed.</p> <p>Patient #3 was admitted to an acute care facility on 10/28/14, during her certification period. On 11/04/14, the RN documented a resumption of care visit. The POC at resumption of care included orders to review blood sugar levels every visit and instruct patient/caregiver about signs and symptoms of hypo/hyperglycemia, nutrition, and diabetic foot care. SN visit notes, dated 11/04/14, 11/06/14, 11/11/14, 11/25/14, and 12/02/14, and signed by the RN Case Manager, did not include documentation of blood sugar levels or teaching about diabetic foot care.</p> <p>During an interview on 12/18/14 at 11:45 PM, the RN Case Manager reviewed Patient #3's record and confirmed she did not assess blood sugar levels. She stated Patient #3's son is her primary caregiver and he will not check the blood sugar levels because he stated it was controlled by her diet. The RN Case Manager confirmed that she did not inform the physician that blood sugar</p>	G 170	<p>Continued:</p> <p>Instruction on patient parameters and improve follow through of physician orders will enhance care delivery as ordered and expected. Education and reminder to clinicians to consistently check and follow physician orders will also solidify proper process and care delivery as ordered. Will be monitored by Clinical Supervisor during review of Oasis completion and patient notes.</p> <p>Persons Responsible: Clinical Supervisor</p>	

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G 170	<p>Continued From page 45</p> <p>levels were not being monitored. She stated education on diabetic foot care was not done.</p> <p>Patient #3's POC was not followed as ordered for blood sugar monitoring and diabetic foot care.</p> <p>5. Patient #10 was a 71 year old female admitted to the agency on 11/14/14 for SN, PT, and OT services. Diagnoses included pneumonitis due to inhalation of vomitus or food, multiple sclerosis, chronic pain, depression, and intestinal infection. Patient #10's record, including the POC, for the certification period 11/14/14 to 1/12/15, was reviewed.</p> <p>Patient #10's POC included orders for the SN to instruct Patient #10 on self catheterization daily. The orders also included instructing Patient #10 about signs and symptoms of a urinary tract infection and catheter care. The RN Case Manager did not document teaching or instructions related to catheterization, catheter care, or urinary tract infections.</p> <p>The RN Case Manager documented 10 visits were made to Patient #10. The SN visit notes dated 11/14/14, 11/17/14, 11/19/14, 11/21/14, 11/24/14, 12/03/14, 12/05/14, 12/09/14, 12/12/14, and 12/15/14 and signed by the RN Case Manager did not document instructing Patient #10 about catheterization, catheter care, or urinary tract infection signs and symptoms.</p> <p>During an interview on 12/17/14 at 9:15 AM, the RN Case Manager confirmed Patient #10 self catheterized and had been doing this for many years. She stated teaching and education were not done because Patient #10 stated she was comfortable with using a catheter. The RN Case</p>	G 170			

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G 170	<p>Continued From page 46</p> <p>Manager stated she was not aware of the order on the POC.</p> <p>Patient #10's POC was not followed for instruction on self catheterization and care.</p> <p>6. Patient #13 was a 91 year old male admitted to the agency on 11/13/14, for SN and PT services. Diagnoses included gallstones, coronary atherosclerosis, diabetes mellitus, pulmonary fibrosis, depression, B-complex deficiencies, and supplemental oxygen. Patient #13's record, including the POC, for the period 11/13/14 to 1/11/15, was reviewed.</p> <p>Patient #13's POC included orders for the SN to instruct Patient #13 on signs and symptoms of hypo/hyperglycemia, proper diabetic foot care, and monitoring blood sugar. The SN was also ordered to instruct Patient #13 on keeping a daily blood sugar log and to review the log with each visit.</p> <p>SN visit notes dated 11/13/14, 11/17/14, 12/08/14, and 12/17/14, and signed by the RN Case Manager, did not document diabetic teaching or blood sugar levels.</p> <p>During an interview on 12/22/14 at 9:55 AM, the RN Case Manager reviewed the record and confirmed no blood sugar levels were documented for Patient #13. She stated he refused to check them and the physician was aware. The RN Case Manager confirmed this information was not documented in her visit notes. She also confirmed diabetic teaching was not documented in her visit notes.</p> <p>Patient #13's POC was not followed for diabetic</p>	G 170			

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G 170	Continued From page 47 monitoring and teaching as ordered by the physician.	G 170			
G 171	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse makes the initial evaluation visit. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure that for 1 of 12 sample patients (Patient #5) for whom SN services were ordered at SOC, the initial comprehensive assessment was completed by an RN. This had the potential to result in unidentified SN needs. Findings include: Patient #5 was an 83 year old male admitted to the agency on 11/19/14, for SN, PT, OT, and HHA services. Diagnoses included aphasia, abnormal gait, coronary atherosclerosis, anxiety, chronic pain, high blood pressure, and a pacemaker. Patient #5's record, including the POC, for the certification period 11/19/14 to 1/17/15, was reviewed. Although SN services were ordered, Patient #5's initial comprehensive assessment, completed on 11/19/14, was signed and dated by a PT. The RN Case Manager for Patient #5 was interviewed on 12/18/14 at 1:45 PM. She stated she made a visit to Patient #5's home on 11/19/14, and started the comprehensive assessment. However, the PT arrived before the assessment was completed. Patient #5 became very anxious with two staff present at the same	G 171	The Home Health Director will in-service clinicians on the regulatory requirement for OASIS completion and that if an RN is ordered at the SOC the RN must completed the OASIS comprehensive assessment. This will monitored on-going by the Clinical Supervisor and through quarterly clinical chart reviews. Agency Policy 6.4 - Outcome and Assessment Information Set (OASIS) will be reviewed an updated to accurately reflect the regulatory requirement. Completion date - 1/20/15 See Attachments: 21,22,23,24,25,26 More thorough patient care, more thorough assessment of patient needs, and completion of POC facilitates improved patient outcomes and reassurance that all patient needs are addressed and met.	1/15/15	

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G 171	Continued From page 48 time. To decrease Patient #5's anxiety, the RN Case Manager said she handed the comprehensive assessment off to the PT to finish, and left the home. She stated the Clinical Director informed her later that when SN services are ordered the RN must complete the initial comprehensive assessment. During an interview on 12/19/14 at 1:20 PM, the PT who signed Patient #5's initial comprehensive assessment, confirmed she finished the assessment, on 11/19/14, on behalf of the RN Case Manager. SN services were ordered for Patient #5, however, his initial comprehensive assessment was not completed by an RN.	G 171	Person Responsible: Home Health Supervisor.	
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. This STANDARD is not met as evidenced by: Based on record review, observation, and patient/family and staff interview, it was determined the agency failed to ensure RNs developed and updated POCs to ensure medical and nursing needs were met, for 4 of 12 patients (#1, #8, #10, and #11), who received SN care and whose records were reviewed. This resulted in incomplete POCs, inadequate patient care, and had the potential to result in negative patient outcomes. Findings include: 1. Patient #11 was an 87 year old male admitted to the agency on 11/08/14, for wound care of	G 173	Inservice given that all areas of patient that are mentioned in oasis must be addressed throughout cert period and that complete documentation of all treatments, assessments, etc. is required. Inservice given to staff on POC development, coordination, and adherence. Discussed all aspects of plan of care, and to utilize all resources available to best construct most beneficial plan to care for patient.	1/15/15

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G 173	<p>Continued From page 49</p> <p>decubitus ulcer stage IV. Additional diagnoses included after care of healing hip fracture, CAD, paralysis agitans, acute poliomyelitis, adjustment of urinary device, change or removal of non-surgical wound dressing and post-surgical aortocoronary bypass. He received SN, PT and OT services. His record, including the POC, for the certification period 11/08/14 to 1/06/15, was reviewed.</p> <p>Patient #11's SN SOC assessment visit, dated 11/08/14, included three wounds, #1 on the right buttock, #2 on the left biceps, and #3 on the left upper quadrante of the abdomen (PEG tube removal site). The POC included an order for the SN to perform skin integrity checks every visit, perform wound care to right buttocks and to treat multiple lacerations to bilateral upper extremity. However, it did not include interventions for wound #3, located at the left upper quadrante of the abdomen.</p> <p>During an interview on 12/18/14 at 11:45 AM, the RN who completed Patient #11's SOC assessment confirmed the POC did not include orders for wound care for wound #3.</p> <p>Patient #11's POC did not include all wound care orders.</p> <p>2. Patient #1 was an 86 year old female admitted to the agency on 10/27/14, for SN and PT services. Diagnoses included left ankle wound, abnormal gait, post-traumatic wound infection, muscle weakness, and history of fall. Patient #1's record, including the POC, for the certification period 10/27/14 to 12/25/14, was reviewed.</p>	G 173	<p>Continued:</p> <p>Inservice staff on proper coordination of POC and need to notify physician and all others involved for any change to POC. Will document all coordination on new coordination form implemented due to this survey.</p> <p>Inservice given to clinicians on following POC. Topics included but are not limited to: Adherence, Correct interventions and treatments, care coordination, and physician notification. Inservice given to staff on establishing, maintaining, reporting and coordination of patient parameters.</p> <p>See attachments: 21,22,23,24,25,26</p>		

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G 173	<p>Continued From page 50</p> <p>- Patient #1's record included an admission communication form, signed by the RN Case Manager, which documented she was at risk for depression, with interventions to be provided by SN services. The interventions were to observe for signs and symptoms of depression, assess effectiveness of medication, and assess for the need of an evaluation by the primary physician. The form also stated the orders and interventions identified would be included on the POC.</p> <p>The POC, signed by the RN Case Manager, did not include orders for assessment and observation of depression signs and symptoms.</p> <p>During an interview on 12/18/14 at 9:55 AM, the RN Case Manager who completed the admission assessment, confirmed the POC did not include orders to assess or observe for depression.</p> <p>Patient #1's POC did not include interventions for depression assessment or management.</p> <p>- Patient #1's record included a SOC assessment dated 10/27/14, and signed by the RN Case Manager, which documented she had two wounds upon admission to the agency. Wound #1 was a left lateral ankle stage II pressure ulcer. Wound #2 was a 2 inch traumatic wound to the back of Patient #1's head. Patient #1's POC did not include orders for the care and treatment of Wound #2.</p> <p>- A SN visit note dated 12/08/14, and signed by the RN Case Manager, documented Patient #1 had a fall in the past with a wound to her left knee which was new since the previous SN visit on 12/03/14. The RN Case Manager further documented the left knee was inflamed. It was</p>	G 173	<p>Improved understanding and POC creation will lead to more focused and improved treatment and modalities as well as improved overall patient care. Inservice proved worthy to staff to remember that a POC is more than just a tangible piece of paper but an overall plan to treat patients and improve their condition. It requires critical thinking and updates as well as overall perspective of patient status.</p> <p>There was also an increased understanding created of need to communicate and coordinate in all aspects in POC management. When reviewing the survey findings with staff there was a clarity in expectation and concept of what a POC should look like and contain to improve patient outcomes and quality of care.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2014
NAME OF PROVIDER OR SUPPLIER TOUCHMARK HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 210 SOUTH TOUCHMARK WAY MERIDIAN, ID 83642		
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G 173	<p>Continued From page 51</p> <p>not documented when the fall occurred or how it occurred. Patient #1's POC was not revised to include care of the newly identified wound.</p> <p>During an interview on 12/18/14 at 9:55 AM, the RN Case Manager reviewed the record and confirmed the two wounds documented at the SOC assessment visit. She confirmed she did not document at subsequent visits about wound #2 because "We were not following the head wound. She was admitted for wound care to her ankle." The RN Case Manager stated she should have monitored wound #2, and documented the wound's progress in the record per agency policy. The RN Case Manager also confirmed documenting the wound to the left knee. She stated she did not know how or when the wound occurred. She stated the wound clinic discovered the wound during Patient #1's visit on 12/05/14. The RN Case Manager stated she did not contact the attending physician, but spoke with the staff at the wound clinic about the wound to the left knee.</p> <p>Patient #1's POC did not address wound care or treatment for all of her wounds identified at the SOC assessment. Additionally, Patient #1's POC was not revised to meet all of her nursing and medical needs when a new wound was identified.</p> <p>3. Patient #10 was a 71 year old female admitted to the agency on 11/14/14, for SN, PT, and OT services. Diagnoses included pneumonitis due to inhalation of vomitus or food, multiple sclerosis, chronic pain, depression, and intestinal infection. Patient #10's record, including the POC, for the certification period 11/14/14 to 1/12/15, was reviewed.</p> <p>Patient #10's POC included orders for the SN to</p>	G 173	<p>Continued:</p> <p>Instruction on patient parameters and improved follow through of physician orders will facilitate care delivery as ordered and expected. Education and reminder to clinicians to consistently check and follow physician orders will also solidify proper process and care delivery as ordered. Will be monitored by Clinical Supervisor during review of Oasis completion and patient notes.</p>		

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G 173	<p>Continued From page 52</p> <p>Instruct Patient #10 on self catheterization daily. The orders also included instructing Patient #10 about signs and symptoms of a urinary tract infection and catheter care.</p> <p>SN visit notes dated 11/14/14, 11/17/14, 11/19/14, 11/21/14, 11/24/14, 12/03/14, and 12/06/14, and signed by the RN Case Manager, documented Patient #10 catheterized herself daily. The SN visit notes dated 12/09/14, 12/12/14, and 12/15/14, and signed by the RN Case Manager, documented no genitourinary problems were identified.</p> <p>During an interview on 12/17/14 at 9:15 AM, the RN Case Manager confirmed Patient #10 self catheterized and had been doing this for many years. She stated there was no teaching or education done because Patient #10 informed the RN Case Manager she was comfortable with using a catheter. The RN Case Manager stated she was not aware of the order on the POC.</p> <p>The POC was not revised to meet the nursing and medical needs of Patient #10.</p> <p>4. Patient #8 was a 71 year old male admitted to the agency on 10/19/14, for SN and, PT services related to decubitus ulcer. Additional diagnoses included pressure ulcer stage III, diabetes type II, long term use of insulin, and dementia. His record, including the POC, for the certification period of 10/19/14 to 12/17/14, was reviewed.</p> <p>During a home visit on 12/15/14 beginning at 1:00 PM, it was observed that Patient #8's left dorsal foot had a new wound. The SN cleaned the wound, applied a topical antibiotic, and a gauze dressing.</p>	G 173	<div style="border: 1px solid black; padding: 5px;"> <p>Persons Responsible: Clinical Supervisor</p> </div>		

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G 173	Continued From page 53 An SN visit note, dated 12/15/14 at 12:50 PM, and signed by the RN Case Manager documented a new open wound on Patient #8's left dorsal foot. However, there was no documentation Patient #8's physician was notified of the new wound. The RN Case Manager was interviewed on 12/17/14 at 12:00 PM. She confirmed, Patient #8 had a new wound on his left dorsal foot. The RN Case Manager confirmed Patient #8's new wound was not communicated to his physician.	G 173	In-services given on new CNA requirements binder, state and federal regulations, and evaluations, new process and binder created to monitor and track all necessary requirements. The Clinical Director will complete the Home Health Aide Annual Competency/Performance review for all C.N.A.'s providing Home Health Services. Currently, there is one Home Health Aide that is due and this review will be completed by 1/20/15 by the Clinical Director. For any new and or back up C.N.A.'s the Clinical Director will be responsible for the review completion. The Billing/Payroll Manager will utilize the agency computer program, Sansio, to track and monitor for compliance with the annual reviews through use of "employee requirements due". A copy of the completed review form will be kept in a binder titled "C.N.A. Requirements" at the agency and a copy will be placed in the employee personnel file. See Attachments: 30,31,32,33,34,35,36,37, 51	1/16/15
G 214	484.36(b)(2)(ii) COMPETENCY EVALUATION & IN-SERVICE TRAINING The HHA must complete a performance review of each home health aide no less frequently than every 12 months. This STANDARD is not met as evidenced by: Based on personnel record review and staff interview, it was determined the facility failed to ensure yearly evaluations were conducted for 1 of 1 home health aide, who had been employed for more than one year. This had the potential to negatively impact quality and safety of patient care. Findings include: Personnel files were reviewed with the Director of Professional Services and Director of Clinical Services on 12/17/14 at 11:55 AM. One aide had been employed for more than one year, with a hire date of 7/01/98. The aide's personnel files	G 214		

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G 214	Continued From page 54 did not include an annual performance review, since 2011. The Director of Clinical Services confirmed the annual evaluations had not been completed.	G 214	Improved documentation, tracking and monitoring of CNA requirements will improve compliance and assure proper CNA education and skills are maintained. Will be monitored monthly by Clinical Supervisor and tracked on monthly tracking form. Person Responsible: Clinical Supervisor.	1/21/15	
G 236	Home health aide performance reviews were not conducted at least every 12 months. 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 review of medical records, agency policy, and staff interview it was determined the agency failed to ensure medical records contained complete and accurate documentation for 1 of 13 patients (Patient #1) whose records were reviewed. This failure had the potential to interfere with clarity of the record and impede coordination and safety of patient care. Findings include: 1. Patient #1 was an 86 year old female admitted to the agency on 10/27/14, for SN and PT services. Diagnoses included left ankle wound, abnormal gait, post-traumatic wound infection, muscle weakness, and history of fall. Patient #1's	G 236			

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G 236	<p>Continued From page 55</p> <p>record including the POC, for the certification period 10/27/14 to 12/25/14, was reviewed.</p> <p>The agency policy, number 9.6 "Wound Management" revised 6/11, stated "Wounds and decubitus ulcers are measured at admission on the OASIS assessment and weekly thereafter using the EZ Graph wound measuring system. The nurse documents measurement of the wound on the skilled nursing note and details of the wound assessment are documented on the EZ Graph form provided." Wound care provided to Patient #1 was not documented consistent with the agency's policy. Examples include:</p> <ul style="list-style-type: none"> - The SOC assessment dated, 10/27/14, and signed by the RN Case Manager, documented Patient #1 had two wounds. Wound #1 was a left lateral ankle stage II pressure ulcer. Wound #2 was a 2 inch traumatic wound to the back of Patient #1's head. Subsequent SN visit notes dated 10/29/14, 10/31/14, 11/04/14, 11/10/14, 11/12/14, 11/14/14, 11/17/14, 11/19/14, 11/24/14, 11/26/14, 12/01/14, 12/03/14, 12/08/14, 12/10/14, 12/12/14, and 12/15/14 did not contain further documentation about wound #2. - An SN visit note dated 12/08/14, and signed by the RN Case Manager, documented Patient #1 had a fall in the past with a wound to her left knee which was new since the previous SN visit on 12/03/14. The RN Case Manager further documented the left knee was inflamed. It was not documented when the fall occurred or how it occurred. <p>During an interview on 12/18/14 at 9:55 AM, the RN Case Manager reviewed the record and confirmed the two wounds documented at the</p>	G 236	<p>Communication and documentation improvements will help maximize care efficiently and create a more rounded plan of care for patients. Establishing effective communication avenues facilitates better understanding of patient conditions and status changes. It also helps to recognize improvements or declines quicker for faster intervention management. Instruction on patient parameters and improved follow through of physician orders will facilitate care delivery as ordered and expected. Education and reminder to clinicians to consistently check and follow physician orders will also solidify proper process and care delivery as ordered. Proper wound care management will decrease infection risk and improve patient outcomes. Thorough wound documentation and wound management will also better coordinate efforts with</p>	

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G 236	Continued From page 56 SOC assessment visit. She confirmed she did not document at subsequent visits about wound #2 because "We were not following the head wound. She was admitted for wound care to her ankle." The RN Case Manager stated she should have monitored wound #2 and documented the wound's progress in the record. The RN Case Manager also confirmed documenting the wound to the left knee. She stated she did not know how or when the wound occurred. She stated the wound clinic discovered the wound during Patient #1's visit on 12/05/14. The RN Case Manager stated she did not contact the attending physician, but spoke with the staff at the wound clinic about the wound to the left knee.	G 236	Continued: multiple physicians, wound clinic, etc. to keep all parties apprised of patient wound status and healing potentials. Will be monitored by Clinical Supervisor during review of Oasis completion and patient notes.		
G 242	Patient #1's record did not include consistent and complete documentation of her wounds. 484.52 EVALUATION OF THE AGENCY'S PROGRAM This CONDITION is not met as evidenced by: Based on staff interview and review of policies, meeting minutes, and quality improvement documents, it was determined the agency failed to ensure an evaluation of the agency's program was conducted that provided useful data to the agency's Governing Body. This impaired the Governing Body's ability to make decisions about the quality of care that was provided to patients. Findings include: 1. Refer to G244 as it relates to the agency's failure to ensure the evaluation consisted of an overall policy and administrative review and a clinical record review.	G 242	Person Responsible: Clinical Supervisor Multiple changes made to leadership, governance, QI, and patient tracking. Please see changes next to corresponding G tags.		

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G 242	Continued From page 57 2. Refer to G245 as it relates to the agency's failure to ensure the evaluation assessed the extent which the agency's program was appropriate, adequate, effective and efficient. 3. Refer to G248 as it relates to the agency's failure to ensure a policy and administrative review. 4. Refer to G249 as it related to the agency's failure to ensure mechanisms were established in writing for the collection of pertinent data to assist in evaluation. 5. Refer to G250 as it relates to the agency's failure to ensure a clinical record review. The cumulative effect of these systemic practices seriously impeded the ability of the agency to determine whether its services were of adequate quality.	G 242	New PAC meeting format created with all information and comment period to be sent to members of governing body. Used regulation to develop format. Accurate record keeping and minutes to be taken at meeting. Also, please note Agency Evaluation, QI, Policy and Procedure review, and Agency Operations report added to meeting agenda. PAC Meeting to occur on Feb. 4 2015. Quarterly Chart Audit Review binder, tracking format, and process. All clinicians to rotate chart audits to improve charting and improve performance. Audits then tracked and trends identified, discussed, and remedied. See Attachments: 10,11,12,13,14,15,16,17	2/4/15	
G 244	484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation consists of an overall policy and administrative review and a clinical record review. This STANDARD is not met as evidenced by: Based on staff interview and review of administrative documents and meeting minutes, it was determined the agency failed to ensure an evaluation, including an overall policy review and a clinical record review, was conducted annually. This resulted in a lack of feedback to determine whether agency programs met patient needs. Findings include:	G 244			

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G 244	Continued From page 58 . PAC meeting minutes, dated 2013 and 2014, were reviewed. Neither an annual evaluation of the agency's program nor clinical record review were mentioned in the minutes. No other documentation was present to indicate an evaluation of the agency's program had been conducted. The Agency Administrator was interviewed on 12/19/14 beginning at 9:00 AM. He validated the advisory board did not have meeting minutes documenting the information covered during the 2013 and 2014 PAC meetings.	G 244	Proper PAC protocol, consistent chart audits, performance tracking, QI, and agency evaluations will improve overall delivery of care and allow for better measurement and care standards. Better record keeping and storage will also help to improve year over year comparisons. Ultimately resulting in improved quality of care.	
G 245	The agency did not conduct a review of its policies or complete clinical record reviews. 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 documents 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 had the potential to result in missed opportunities to increase efficiency and improve patient care. Findings include: The document "ANNUAL AGENCY	G 245	Persons Responsible: Home Health Director. New PAC meeting format created with all information and comment period to be sent to members of governing body. Used regulation IDAPA 16.03.07 to develop format. Accurate record keeping and minutes to be taken at meeting. Also, please note Agency Evaluation, QI, Policy and Procedure review, and Agency Operations report added to meeting agenda. PAC Meeting to occur on Feb. 4 2015 Quarterly Chart Audit Review binder, tracking format, and process. All clinicians to rotate	2/4/15

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G 245	Continued From page 59 EVALUATION," dated 2013 and 2014, was included with the agency's Professional Advisory Board Committee meeting minutes. It contained items regarding the agency's operations, including sources of referral, a chart listing reasons patients were admitted for service, "Home Health Compare" data, etc. In addition, the evaluation only presented data. No analysis of the data was completed. Additionally, there was no documentation of clinical record reviews to assess appropriateness and effectiveness of patient care. The Administrator and the Director of Professional Services were interviewed on 12/19/14 beginning at 9:00 AM. They both confirmed the evaluation did not include data analysis, conclusions or comparisons. The agency evaluation did not assess the extent to which the agency's program was appropriate, adequate, effective and efficient.	G 245	Continued: chart audits to improve charting and improve performance. Audits then tracked and trends identified, discussed, and remedied. See Attachments: 10,11,12,13,14,15,16,17,51, Proper PAC protocol, consistent chart audits, performance tracking, QI, and agency evaluations will improve overall delivery of care and allow for better measurement and care standards. Improved record keeping and storage will also help to improve year over year comparisons. Ultimately resulting in improved quality of care. Chart Audits Will be monitored monthly by Clinical Supervisor and tracked on tracking form .	2/4/15
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. This STANDARD is not met as evidenced by: Based on review of administrative documents, agency policies, and staff interview, it was determined the agency failed to ensure an annual	G 248	Person Responsible: Home Health Director Policy Procedure Review Binder created. All new and updated policies to be presented and reviewed at all PAC meetings and more frequent if needed. Also agency evaluation to be reviewed and discussed.	

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G 248	<p>Continued From page 60</p> <p>evaluation, including an evaluation of policies and administrative practices of the agency, was conducted. This resulted in a lack of feedback to agency staff. Findings include:</p> <p>An agency policy, number 4.1 "PROFESSIONAL POLICY-MAKING COMMITTEE", dated 06/11, stated "The professional policy-making committee shall take responsibility to advise the board of directors regarding agency policies on professional issues through regular review." The policy discussed what policies are to be reviewed.</p> <p>The document "ANNUAL AGENCY EVALUATION," dated 2013 and 2014, was included with the agency's Professional Advisory Board Committee meeting minutes. It contained information regarding the agency's review of the PAC's quarterly meeting minutes dated 2013 and 2014.</p> <p>A review of the PAC's quarterly meeting minutes dated 2014, revealed a list of the items below:</p> <p>Scope of services offered Admission and discharge policy Plan of Care Emergency care Clinical records Personnel qualifications Program evaluation Review of by-laws Budget and capitalization review</p> <p>The PAC did not maintain meeting minutes to document what was discussed, and action taken, related to the listed items.</p> <p>During an interview with the Administrator on</p>	G 248	<p>The complete policy manual for Touchmark Home Health will be reviewed by Daphne King and Winona Phelps, RN representatives from the Touchmark Central Office. This review and any possible revisions will be completed no later than February 5, 2015. The policies previously outlined under other G tags will be completed by the dates previously noted. Ongoing monitoring, review and revisions will be conducted by the agency as part of their Annual Agency Evaluation.</p> <p>See Attachment: 10,11,12</p> <p>Continuous review and approval of policies will improve compliance and adequately measure branch performance.</p> <p>Person Responsible: Home Health Director.</p>	

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G 248	Continued From page 61 12/19/14 beginning at 9:00 AM, he verified the PAC did not have meeting minutes, only the list of topics.	G 248	New PAC meeting format created with all information and comment period to be sent to members of governing body. Used regulation IDAPA 16.03. 07 to develop format. Accurate record keeping and minutes to be taken at meeting. Also, please note Agency Evaluation, QI, Policy and Procedure review, and Agency Operations report added to meeting agenda. PAC Meeting to occur on Feb. 4 2015. Quarterly Chart Audit Review binder, tracking format, and process. All clinicians to rotate chart audits to improve charting and improve performance. Audits to then be tracked and trends identified, discussed, and remedied. See Attachments: 10,11,12	2/4/15
G 249	The Administrator was interviewed on 12/19/14 beginning at 9:00 AM. He verified no documentation of an overall annual policy review was available. Agency policies were not reviewed as part of the annual evaluation. 484.52(a) POLICY AND ADMINISTRATIVE REVIEW Mechanisms are established in writing for the collection of pertinent data to assist in evaluation. This STANDARD is not met as evidenced by: Based on 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 that would collect data for the evaluation. Findings include: During an interview on 12/19/14 beginning at 9:00 AM, the Director of Professional Services stated she could not provide documentation of viable data collection for the agency. She stated the agency had not completed a clinical record review. On 12/22/14 at 9:10 AM, the Director of Professional Services, was asked if data demonstrating assessment of the quality and effectiveness of the agency's services was available. She stated she could not produce	G 249		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2014
NAME OF PROVIDER OR SUPPLIER TOUCHMARK HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 210 SOUTH TOUCHMARK WAY MERIDIAN, ID 83842		
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G 249	Continued From page 62 anything.	G 249	Continued: comparisons. Ultimately resulting in improved quality of care.	1/5/15	
G 250	Mechanisms were not established to guide the agency's annual evaluation. 484.52(b) CLINICAL RECORD REVIEW	G 250	Person Responsible: Home Health Director		
	At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. This STANDARD is not met as evidenced by: Based on policy review and staff interview, it was determined the agency failed to ensure health professionals representing the scope of the program took part in a quarterly record review. This resulted in a lack of participation by agency staff. Findings include: An agency policy "Clinical Record Audits," dated 2/23/09, stated, "Quarterly charts equalling 10% of quarterly average census will be reviewed by the Corporate Nurse Consultant or designee." The Clinical Director was interviewed on 12/16/14 at 3:00 PM. She stated, It was her responsibility to conduct patient record audits. She confirmed, a quarterly record review of the agency's active and closed patients had not been completed.		10% of active and closed clinical records will be reviewed and kept in Quarterly Chart Audit Review binder, new tracking and summary format, and process. All clinicians to rotate chart audits to improve charting and improve performance. Audits to then be tracked and trends identified, discussed, and remedied. See Attached: 13,14,15,16,51		
G 330	484.55 COMPREHENSIVE ASSESSMENT OF	G 330	Consistency in quarterly chart audits will give a better way to identify and track trends as well as diagnose agency problems which will allow for efficient agency improvements. Monitored on monthly tracking form Person Responsible: Clinical Supervisor		

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G 330	Continued From page 63 PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary This CONDITION is not met as evidenced by: Based on review of medical records, agency policy, and staff interview, it was determined the agency failed to ensure comprehensive assessments accurately reflected patients' current health status and included a comprehensive medication review. This resulted in immediate jeopardy to the health and safety of one patient, and impeded the agency's ability to provide consistent care necessary to meet the needs, and promote the health and safety, of all patients receiving services. Findings include: 1. Refer to G331 as it relates to the failure of the agency to ensure the completion of a	G 330	Multiple changes made for the assessment and patient status monitoring. Please see changes next to corresponding G tags:	

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G 330	Continued From page 64 comprehensive assessment at the SOC. 2. Refer to G335 as it relates to the failure of the agency to ensure the complete assessments were performed by a qualified professional. 3. Refer to G337 as it relates to the failure of the agency to ensure the comprehensive assessment included a medication review to obtain a current list of patient medications, evaluate for drug interactions, and identify possible significant side effects. These failures placed one patient at imminent risk of serious harm or death. The cumulative effect of these negative systemic practices placed the health and safety of one patient in immediate jeopardy and significantly compromised the ability of the agency to provide safe and appropriate care.	G 330			
G 331	484.55(a)(1) INITIAL ASSESSMENT VISIT A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the agency failed to ensure the SOC comprehensive assessment for 1 of 13 patients (Patient #5) whose records were reviewed, was accurate and thorough. This had the potential to result in unmet patient needs and adverse patient outcomes. Findings include: Patient #5 was an 83 year old male admitted to	G 331	Staff inserviced on determining all patient needs and that POC addresses all areas of patient wellbeing. Inservice given to staff on POC development, coordination, and adherence. Discussed all aspects of plan of care for patient. See Attachments: 21,22,23,24,25,26	1/15/15	

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G 331	<p>Continued From page 65</p> <p>the agency on 11/19/14, for SN, PT, OT, and HHA services. Diagnoses included aphasia, abnormal gait, coronary atherosclerosis, anxiety, chronic pain, high blood pressure, and a pacemaker. Patient #5's record, including the POC, for the certification period 11/19/14 to 1/17/15, was reviewed.</p> <p>Patient #5's home health medical record included a copy of a History and Physical (H&P) assessment from his hospitalization on 9/23/14. It was faxed to the agency on 11/17/14, from the SNF Patient #5 was discharged from on 11/18/14. The Past Surgical History section of the hospital H&P assessment stated Patient #5 had previously undergone a right knee replacement. However, his right knee replacement was not noted in Patient #5's SOC comprehensive assessment, completed on 11/19/14, or his POC.</p> <p>The RN Case Manager who completed the "Musculoskeletal" section of the SOC comprehensive assessment was interviewed on 12/18/14 starting at 1:45 PM. She confirmed the right knee replacement was not documented on Patient #5's assessment.</p> <p>The 9/23/14 hospital H&P assessment also stated Patient #5 was allergic to penicillin, contrast dye, shellfish, and morphine. Patient #5's home health record also included a copy of a 10/02/14 SNF Admission Record, faxed to the agency from the SNF on 11/17/14. The SNF Admission Record indicated Patient #5 was also allergic to iodine. Patient #5's SOC comprehensive assessment listed Patient #5's allergies as penicillin and seafood. Patient #5's SOC comprehensive assessment did not include his allergies to contrast dye, morphine, and</p>	G 331	<div style="border: 1px solid black; padding: 5px;"> <p>Improved patient care, more thorough assessment of patient needs, and completion of POC facilitates improved patient outcomes and reassurance that all patient needs are addressed and met. Will be monitored by Clinical Supervisor during review of Oasis completion and patient notes.</p> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 20px;"> <p>Person Responsible: Clinical Supervisor</p> </div>	

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G 331	Continued From page 66 iodine. Additionally, it did not state that his seafood allergy was specific to shellfish. During an interview on 12/19/14 at 1:20 PM, the PT that completed the allergy section of Patient #5's SOC comprehensive assessment confirmed the allergy discrepancies. She stated the comprehensive assessment included the allergies mentioned by the patient and his spouse at the time the assessment was completed. An agency policy, number 6.6, regarding standards of client care, revision date 2009, stated "Assessment begins with the professional's first encounter with the client and involves the systematic collection of data regarding the needs of the client ...The professional will assess the client's health status, within the time frame established, by physical observation and examination, review of records, consultation, and communication with the client/caregiver." Patient #5's SOC comprehensive assessment did not reflect review of pertinent records, as stated in the policy. Patient #5's SOC comprehensive assessment did not accurately reflect his health status.	G 331			
G 335	484.65(b)(2) COMPLETION OF THE COMPREHENSIVE ASSESSMENT Except as provided in paragraph (b)(3) of this section, a registered nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. This STANDARD is not met as evidenced by:	G 335	Staff inserviced on determining all patient needs and that POC addresses all areas of patient wellbeing. Inservice given to staff on POC development, coordination, and adherence.	1/15/15	

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G 335	<p>Continued From page 67</p> <p>Based on record review and staff interview it was determined the agency failed to ensure that for 1 of 12 sample patients (Patient #5) for whom SN services were ordered at SOC, the initial comprehensive assessment was completed by an RN. This had the potential to result in unidentified and unmet SN needs. Findings include:</p> <p>Patient #5 was an 83 year old male admitted to the agency on 11/19/14, for SN, PT, OT, and HHA services. Diagnoses Included aphasia, abnormal gait, coronary atherosclerosis, anxiety, chronic pain, high blood pressure, and a pacemaker. Patient #5's record, including the POC, for the certification period 11/19/14 to 1/17/15, was reviewed.</p> <p>Although SN services were ordered, Patient #5's initial comprehensive assessment, completed on 11/19/14, was signed and dated by a PT.</p> <p>The RN Case Manager for Patient #5 was interviewed on 12/18/14 at 1:45 PM. She stated she made a visit to Patient #5's home on 11/19/14, and started the comprehensive assessment. However, the PT arrived before the assessment was completed. Patient #5 became very anxious with two staff present at the same time. To decrease Patient #5's anxiety, the RN Case Manager stated she handed the comprehensive assessment off to the PT to finish, and left the home. She stated the Clinical Director informed her later that when SN services are ordered the RN must complete the initial comprehensive assessment.</p> <p>During an interview on 12/19/14 at 1:20 PM, the PT who signed Patient #5's initial comprehensive</p>	G 335	<p>Continued: Discussed all aspects of plan of care for patient. See Attachments: 21,22,23,24,25,26</p> <p>Improved patient care, more thorough assessment of patient needs, and completion of POC enhances improved patient outcomes and reassurance that all patient needs are addressed and met. Will be monitored by Clinical Supervisor during review of Oasis completion and patient notes.</p> <p>Person Responsible: Clinical Supervisor</p>		

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G 336	Continued From page 68 assessment, confirmed she finished the assessment, on 11/19/14, on behalf of the RN Case Manager.	G 336		
G 337	SN services were ordered for Patient #5, however, his initial comprehensive assessment was not completed by an RN. 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 in the home, and patient and staff interview it was determined the facility failed to ensure a comprehensive drug regimen review for 7 of 13 patients (#1, #3, #5, #7, #8, #10, and #13) whose records were reviewed. This failure placed Patient #10 in immediate jeopardy for serious injury, harm, or death. This had the potential to affect all patients under the care of the agency, and place them at risk for adverse events, duplicative drug therapy, or negative drug interactions. Findings include: The agency policy, number 9.3 "Medication Administration/Management" revised 6/11, stated "All known over-the-counter medications taken on a (PRN) basis and all routine medications are listed on the drug profile at the time of the client's admission to the agency." It further stated, the medication profile was updated with all	G 337	Staff inserviced on new patient medication process and Medication Administration Management and Drug Interaction, Identification, Physician Notification, and Adverse Drug Reaction policies reviewed. See Attachments and Immediate Jeopardy Action Plan: 44,45,46,47,48,49,50	1/19/15

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G 337	<p>Continued From page 69</p> <p>medication changes, and documented on the medication profile, as well as in the visit note.</p> <p>The agency policy, number 9.3.1 "Drug Interaction Identification and Physician Notification" revised 6/11, stated "Upon admission to the agency, all patient medications will have a drug interaction summary report, and will be generated for every patient and filed in the patient's medical record. A copy will be given to the Case Manager (RN) to review. Any identified drug interactions with a Significance Rating of "major" will be printed, and sent to the physician for review and signature."</p> <p>During an interview on 12/18/14 at 9:55 AM, the Clinical Director was asked to explain the process for medication reconciliation and medication interaction review, for patients admitted to the agency. She stated when a medication list was received at the time of referral it was given to the RN Case Manager assigned to complete the SOC assessment visit. The RN Case Manager was to review the list, along with medications in the patient's home at the visit. The Clinical Director stated during the visit, the RN Case Manager answered the questions on the SOC assessment, regarding medication review and whether the attending physician was contacted. After the SOC visit, the medication list was given to the office personnel and entered into the computer software program. The computer software identified interactions and a report was printed. The Clinical Director stated the medication interaction report was faxed by either herself, or office personnel, to the attending physician for review and signature. She stated the RN Case Managers did not have access to the electronic software that contains the</p>	G 337	<p>Patient care and medication assessment will be greatly improved with the new medication process established. Consistent review and monitoring of patient medication regimen will lead to improved medication compliance and consistency in med lists for all concerned in caring for the patients. There is also a greater understanding in the need for all disciplines to be checking for new medications and coordinating and communicating all new medications found. Will be monitored by Clinical Supervisor during review of Oasis completion and patient notes.</p> <p>Persons Responsible: Clinical Supervisor</p>		

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G 337	<p>Continued From page 70</p> <p>medication list. The Clinical Director confirmed the medication review, in the software program, was not always completed the day of the SOC assessment.</p> <p>1. Patient #10 was a 71 year old female admitted to the agency on 11/14/14, for SN, PT, and OT services. Diagnoses included pneumonitis due to inhalation of vomitus or food, multiple sclerosis, chronic pain, depression, and intestinal infection. Patient #10's record, including the POC, for the period 11/14/14 to 1/12/15, was reviewed.</p> <p>Patient #10's record included an H&P from the hospital where she was a patient, from 11/04/14 to 11/12/14 (admission #2). The H&P stated Patient #10 was found unresponsive in her home by her significant other. EMS was called to the home and Patient #10 was given Narcan. The Drugs.com website, accessed 1/09/15, stated Narcan is a medication used to reverse the effect of narcotic medications. Patient #10 was intubated (a plastic tube is placed down the windpipe and into the lungs to provide an airway) in the emergency room of the hospital due to an altered mental status. Patient #10 was diagnosed with respiratory failure related to altered mental status. The H&P included Patient #10's past medical history which included: history of multiple intubations for respiratory failure, opioid dependence, and chronic use of benzodiazepenes (medications used as sedatives, hypnotics, anticonvulsants and muscle relaxants).</p> <p>The H&P stated Patient #10 was discharged from the hospital on 10/30/14 (admission #1), after staying for 1 week, 5 days prior to admission #2. During that admission she was diagnosed with</p>	G 337			

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G 337	<p>Continued From page 71</p> <p>hypoxic respiratory failure. The National Institutes of Health website, accessed 1/09/15, defined hypoxic respiratory failure as a condition in which not enough oxygen passes from your lungs into your blood. The H&P stated Patient #10 was also intubated during admission #1.</p> <p>Patient #10's record included a discharge summary from admission #2. The discharge summary was sent to the agency at the time her referral for home health services on 11/12/14. It included a list of the medications Patient #10 was to take at home. The list also included medications which Patient #10 had been taking at home prior to her admission. Both the discharge summary and the discharge medication reconciliation orders stated Patient #10 was to stop taking the following medications: Percocet (oxycodone/acetaminophen), morphine IR, oxycodone IR, senna, and Fioricet.</p> <p>a. A visit was made to Patient #10's home, on 12/16/14 at 3:30 PM, to observe an OT visit. Patient #10 was observed to be drowsy. During the visit a request was made to view her medications. Patient #10 went into a bedroom and pulled open a dresser drawer containing several pill bottles.</p> <p>The following medications, which were ordered to be discontinued following hospital admission #2, were observed: morphine IR 30 mg, morphine IR 15 mg, oxycodone 15 mg, oxycodone/acetaminophen 10 mg/325 mg, senna, and Fioricet. Patient #10 stated she was currently taking these medications.</p> <p>Patient #10 stated she was not taking the following medications listed on her home health</p>	G 337			

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G 337	<p>Continued From page 72</p> <p>POC and medication list: Baclofen, Norco, and Provigil.</p> <p>During an interview with Patient #10 on 12/16/14 at 3:30 PM, she confirmed she was taking morphine IR 30mg, morphine IR 15 mg, oxycodone 15 mg, and oxycodone/acetaminophen 10 mg/325 mg for chronic back pain. Patient #10 was asked about her medication management. She stated her significant other set up her medications for the day, but she took her pain medication as needed throughout the day. Patient #10 showed the surveyor a notepad on the dresser where she stated she wrote down when she took her pain medication and how many of each pill she took.</p> <p>During an interview on 12/17/14 at 9:15 AM, the RN Case Manager reviewed Patient #10's record and medication list. She stated during the SOC assessment on 11/14/14, she used the medication list from the hospital discharge summary to develop a list of Patient #10's current medications for the POC.</p> <p>A second home visit was made to Patient #10's home on 12/18/14 at 1:15 PM with the RN Case Manager. Patient #10 stated "I'm having trouble keeping my eyes open." During the visit the RN Case Manager requested to view all of the medications Patient #10 was taking and reconciled them with the medications listed on her POC. The following medications in Patient #10's home were not prescribed by the attending physician who certified her home health POC, and were not listed on her POC:</p> <p>-Morphine IR 30 mg 2-3 tablets, 3 times daily; the label indicated 168 pills were dispensed on</p>	G 337		

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G 337	<p>Continued From page 73 12/02/14</p> <p>-Morphine IR 15 mg 1-2 tablets, every 4-6 hours, maximum 8 pills daily; the label indicated 180 pills were dispensed on 12/02/14</p> <p>-Morphine IR 15 mg 1-2 tablets, every 4-6 hours; the label indicated 180 pills were dispensed on 9/03/14</p> <p>-Oxycodone 15 mg 1-2 tablets, every 4-6 hours, maximum 5 pills daily; the label indicated 140 pills were dispensed on 12/02/14</p> <p>-Percocet 10 mg/325 mg 2-4 tablets, 3 times daily, maximum 5 pills daily; the label indicated 140 pills were dispensed on 12/02/14</p> <p>-Fioricet 50/325/40 1-2 tablets, every 4-6 hours; the prescription was dispensed on 12/15/14</p> <p>Additionally, Patient #10's POC included Clonazepam 1 mg 1/2 tablet, 2 times daily as needed. However, the Clonazepam in her home was labeled 2 mg, with instructions to take 1 tablet, 2 times daily.</p> <p>Patient #10's notepad, dated 12/18/14, contained the following handwritten notes:</p> <p>-6:25 AM 1 oxycodone, 2 morphine</p> <p>-6:30 AM 1 Fioricet</p> <p>-10:00 AM 1.5 oxycodone, 2 morphine</p> <p>-10:30 AM 1 oxycodone, 2 morphine</p> <p>The package insert for Oxycodone, from</p>	G 337			

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G 337	<p>Continued From page 74</p> <p>Mallinckrodt Pharmaceuticals accessed 1/09/15, stated "Respiratory depression is the chief hazard from all opioid agonist preparations. Respiratory depression occurs most frequently in elderly or debilitated patients, usually following large initial doses in non-tolerant patients, or when opioids are given in conjunction with other agents that depress respiration."</p> <p>The package insert for Morphine, from Mallinckrodt Pharmaceuticals accessed 1/09/15, stated "Respiratory depression is the primary risk of morphine sulfate. Respiratory depression occurs more frequently in elderly or debilitated patients and in those suffering from conditions accompanied by hypoxia, hypercapnia, or upper airway obstruction, in whom even moderate therapeutic doses may significantly decrease pulmonary ventilation."</p> <p>During a phone interview on 12/17/14 at 3:05 PM, Patient #10's primary physician stated her last appointment was on 12/05/14. Her primary physician stated he was unaware she was taking the medications Morphine and oxycodone. He further stated he had not prescribed these medications for Patient #10.</p> <p>Patient #10's medication assessment and reconciliation was not comprehensive. It did not include identification of duplicative therapy and discrepancies, which placed her at increased risk for adverse reactions.</p> <p>b. An SN visit note dated 11/19/14, and signed by the RN Case Manager documented Patient #10 stated she had pain which measured 9/10 on a pain scale. The RN Case Manager documented Patient #10 took oxycodone which helped relieve</p>	G 337			

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G 337	<p>Continued From page 75</p> <p>her pain. The visit note also indicated there were no medication changes since the last SN visit. Oxycodone was not listed on Patient #10's POC or patient medication list. This medication was to be discontinued, per the hospital.</p> <p>- An SN visit note, dated 11/21/14, and signed by the RN Case Manager, documented Patient #10 had pain in her back and hips which she measured 9/10 on a pain scale. The RN Case Manager documented Patient #10 had taken the pain medication morphine which helped relieve her pain. Morphine was not listed on Patient #10's POC or patient medication list. This medication was to be discontinued, per the hospital.</p> <p>During an interview on 12/17/14 at 9:15 AM, the RN Case Manager reviewed her visit notes. She confirmed she documented Patient #10 took the pain medications morphine and oxycodone. The RN Case Manager also confirmed the 2 medications were not listed on Patient #10's medication list or POC.</p> <p>Patient #10's medication list and POC were inaccurate and not reconciled for discrepancies or changes.</p> <p>c. Patient #10's SOC assessment was completed on 11/14/14, by the RN Case Manager. The assessment documented no problems were found during Patient #10's medication review. Patient #10's record contained a medication interaction detail report, dated 11/17/14, listing the following medication interactions:</p> <p>- A severity level of "major" was identified between Venlafaxine HCL and Sumatriptan. The</p>	G 337			

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G 337	<p>Continued From page 76</p> <p>warning stated that taking these medications concurrently may result in a life-threatening condition called Serotonin syndrome.</p> <p>The National Institutes of Health website, accessed 12/23/14, defined Serotonin syndrome as an increase of Serotonin released or available in the brain. Serotonin is a chemical in the body that helps nerves and muscles. An increase of this chemical in the body may cause high body temperature, blood pressure changes, confusion, muscle spasms, or seizures. It further stated Serotonin syndrome must be treated quickly, and if untreated, is deadly.</p> <p>- A severity level of "major" was identified between Norco and Clonazepam. The warning stated that taking these medications concurrently may result in respiratory depression.</p> <p>The medication review was not comprehensive. Interactions were checked for the medications listed on Patient #10's POC. However, Patient #10 was taking pain medications not listed on her POC.</p> <p>Drugs.com, an internationally recognized database and public access website was established as a standard for nurses and clinical staff in determination of drug interactions. Patient #10's medications, including those in her home but not on her POC, were entered into the database to determine interactions. Eight clinically significant interactions were noted to increase side effects such as drowsiness, dizziness, and difficulty with concentration. Related to Clonazepam, the same website stated "The sedative effects of clonazepam may last longer in older adults. Accidental falls are</p>	G 337			

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G 337	<p>Continued From page 77 common in elderly patients who take benzodiazepines."</p> <p>Patient #10's record included a SN visit note, dated 12/03/14, and signed by the RN Case Manager, which documented Patient #10 fell one week prior and sprained her left ankle. A physical therapy note, dated 12/04/14, and signed by the PTA, documented Patient #10 fell from her bed in the morning and bumped her forehead on the dresser. The PTA also documented a 1 inch cut to the left side of Patient #10's forehead. A subsequent SN visit note, dated 12/05/14, documented Patient #10 had fallen 3 times that morning.</p> <p>During an interview with the RN Case Manager on 12/17/14 at 9:15 AM, she reviewed Patient #10's record and medication list. She stated at the SOC assessment on 11/14/14, the medication list from the hospital discharge summary was used for the POC medication list. The RN Case Manager stated medications listed on the POC were entered into the software program by office personnel at the agency, and she had no access to the computer program. She stated if interactions were found a report would automatically be printed and the office personnel would fax the report to the physician's office for review. The RN Case Manager confirmed she documented no problems were found during the review at the time of the SOC assessment without having knowledge of any possible medication interactions. She stated once the interaction report was printed she did not correct her answer to indicate interactions were found. The RN Case Manager confirmed she did not contact Patient #10's physician about the medication interactions.</p>	G 337			

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G 337	Continued From page 78 Patient #10 was determined to be in immediate jeopardy for serious injury, harm, or death due to an increased risk of respiratory depression and falls, related to concurrent use of high risk medications. The agency failed to accurately note all medication at the time of admission and failed to comprehensively assess and reconcile medications Patient #10 was currently taking in her home. NOTE: The Director of Professional Services was notified of the immediate jeopardy on 12/19/14 at 12:45 PM, and provided a evidence of corrective actions taken on 12/22/14. These included the following: -Immediate completion of an accurate medication list with reconciliation -Identify all physicians who ordered medications for Patient #10, their health care role -Send the accurate medication list to all ordering physicians for review and comment. -Based on comments from ordering physician, complete updated medication list, and have it signed by the attending physician. -Contact Patient #10 and her caregiver for a home visit to review the corrected list of ordered medications -Create a plan for Patient #10 for increased compliance with her medication regimen -Determine Patient #10's, and her caregiver's, understanding of medication compliance -Determine Patient #10's understanding of health and safety risks with non-compliance of her prescribed medications The agency's Plan of Correction was reviewed and accepted. All of the above steps were	G 337			

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G 337	<p>Continued From page 79</p> <p>completed and verified. Two of Patient #10's pain medications were placed on hold by her attending physician, Morphine IR 15 mg and Percocet 10 mg/325 mg. A visit was made to the patient's home on 12/22/14 at 2:20 PM, by the RN Case Manager and the Director of Professional Services. The medication changes were explained to her and her significant other. The immediate jeopardy was abated and the agency was notified of the abatement following the home visit.</p> <p>2. Patient #1 was an 86 year old female admitted to the agency on 10/27/14, for SN and PT services. Diagnoses included left ankle wound, abnormal gait, post-traumatic wound infection, muscle weakness, and history of fall. Patient #1's record, including the POC, for the certification period 10/27/14 to 12/25/14, was reviewed.</p> <p>Patient #1's record included a "Patient Medication List." The form was signed and dated 12/10/14, by the RN Case Manager. The medications listed on the report matched the medications on Patient #1's POC, signed by her physician on 11/25/14.</p> <p>A visit was made to the assisted living facility where Patient #1 resided, on 12/15/14, to observe a SN visit. During the visit a request was made to view the medication list the assisted living facility had for Patient #1. The following discrepancies were noted:</p> <p>a. Patient #1's medication list and POC included Combigan solution (used for glaucoma) one drop in both eyes twice daily. The medication list at the facility listed one drop in the right eye twice daily, effective 12/12/14.</p>	G 337		

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G 337	<p>Continued From page 80</p> <p>b. The medication list at the facility included Paroxetine (used for anxiety and/or depression) 10 mg, to be taken at bedtime daily. This medication was started on 12/08/14. Paroxetine was not included on Patient #1's patient medication list or POC.</p> <p>During an interview on 12/18/14 at 9:55 AM, the RN Case Manager confirmed the patient medication list in Patient #1's record and the medication list at the facility were different. She stated she had not updated the medication list in her home health record, and she would speak with facility staff for verification.</p> <p>Patient #1's medication review and reconciliation was not complete or comprehensive.</p> <p>3. Patient #3 was a 96 year old female admitted to the agency on 10/16/14, for SN, PT, and HHA services. Diagnoses included rehabilitation services, muscle weakness, abnormal gait, atrial fibrillation, high blood pressure, history of fall, and stroke. Patient #3's record, including the POC, for the certification period 10/16/14 to 12/14/14, was reviewed.</p> <p>Patient #3's medication list included Warfarin (medication to thin the blood and prevent clot formation). Warfarin, a commonly used anticoagulant to prevent blood clots, interacts with many medications including antibiotics, over the counter medications, and herbal medications according to the Nursing 2015 Drug Handbook (Wolters Kluwer Publishing).</p> <p>The SOC assessment was completed on 11/04/14, by the RN Case Manager. She documented no problems were found during</p>	G 337			

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G 337	<p>Continued From page 81</p> <p>Patient #3's medication review. Patient #3's record contained a medication interaction detail report, dated 11/06/14, listing the following medication interactions:</p> <ul style="list-style-type: none"> - A severity level of "major" was identified between Warfarin and Fish Oil. The warning stated that taking these medications concurrently may result in an increased risk of bleeding. - A severity level of "moderate" was identified between Losartan Potassium and Potassium Chloride. The warning stated taking these medications concurrently may result in high potassium levels. Patient #3's POC included a diagnosis of atrial fibrillation. High potassium levels in the blood may cause life threatening abnormal heart rhythms, according to the Mayo Clinic website, accessed 1/15/14. <p>During an interview on 12/18/14 at 11:45 AM, the RN Case Manager reviewed the record and confirmed she documented no problems were found during the medication review on the SOC visit note. She stated she completed the documentation during her assessment visit. Later, the personnel in the agency office, entered the medications into the computer software program to check for interactions. The RN Case Manager confirmed she did not amend her answer to the question when the interactions were found.</p> <p>Patient #3's medication review and reconciliation were inaccurate.</p> <p>4. Patient #5 was an 83 year old male admitted to the agency on 11/19/14, for SN, PT, OT, and HHA services. Diagnoses included aphasia,</p>	G 337			

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G 337	<p>Continued From page 82</p> <p>abnormal gait, coronary atherosclerosis, anxiety, chronic pain, high blood pressure, and a pacemaker. Patient #5's record, including the POC, for the certification period 11/19/14 to 1/17/15, was reviewed.</p> <p>Upon review of Patient #5's record the following medication discrepancies were found:</p> <p>Patient #5's record included a physician order sheet, dated 11/20/14, and signed by the RN Case Manager, requesting clarification of his medication orders from the attending physician. The RN Case Manager documented on the order sheet Patient #5's spouse inquired whether he should continue taking Candesartan, Hydrochlorothiazide, and Ropinirole. Patient #5 had been taking these medications at home prior to his admission to a SNF.</p> <p>Patient #5's physician returned the form to the agency via fax, dated 11/24/14, with orders for Lisinopril and Amlodipine (blood pressure medications) to be taken daily. His physician did not address the 3 medications specified in the request from the RN Case Manager.</p> <p>During an interview on 12/18/14 at 11:40 AM, the RN Case Manager reviewed the record and confirmed Patient #5's physician did not address the specific medications that she inquired about. She stated she called the office of Patient #5's physician the following morning and spoke with a nurse in his office for further clarification. The RN Case Manager confirmed she had not documented the physician contact, or what was discussed in Patient #5's record.</p> <p>Patient #5's record did not include evidence the</p>	G 337			

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G 337	<p>Continued From page 83 discrepancies were reconciled.</p> <p>5. Patient #7 was a 98 year old female admitted to the agency on 11/22/14, for SN, PT, and HHA. Diagnoses included surgery, pacemaker, atrial fibrillation, broken heart syndrome, heart attack, history of fall, and urinary tract infection. Patient #7's record, including the POC, for the certification period 11/22/14 to 1/20/15, was reviewed.</p> <p>The SOC assessment was completed on 11/22/14, by the RN. She documented no problems were found during Patient #7's medication review. Patient #7's record contained a medication interaction detail report, dated 11/26/14, listing the following medication interactions:</p> <ul style="list-style-type: none"> - A severity level of "major" was identified between Lisinopril (a blood pressure medication) and Potassium Chloride (a potassium supplement). The warning stated that taking these medications concurrently may result in an increased level of potassium in the blood. High potassium levels in the blood may cause life threatening abnormal heart rhythms according to the Mayo Clinic website, accessed 1/15/14. - A severity level of "moderate" was identified between Lisinopril and Furosemide (a diuretic used to treat high blood pressure). The warning stated taking these medications concurrently may result in severe postural hypotension (a drop blood pressure when standing up from sitting or lying, that may cause dizziness or fainting). <p>During an interview on 12/18/14 at 3:15 PM, the RN who completed the SOC assessment and</p>	G 337			

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G 337	<p>Continued From page 84</p> <p>medication review confirmed she had documented no problems were found. She stated the medication interaction report was not completed until 4 days after the SOC assessment, and she had no access to the computer software program to determine interactions. The RN confirmed she did not correct her answer after the report was printed.</p> <p>Patient #7's medication review, completed and documented at his SOC assessment, was not accurate.</p> <p>6. Patient #13 was a 91 year old male admitted to the agency on 11/13/14, for SN and PT services. Diagnoses included gallstones, coronary atherosclerosis, diabetes mellitus, pulmonary fibrosis, depression, B-complex deficiencies, and supplemental oxygen. Patient #13's record, including the POC, for the certification period 11/13/14 to 1/11/15, was reviewed.</p> <p>The SOC assessment was completed on 11/13/14, by the RN Case Manager. She documented no problems were found during Patient #13's medication review. The RN Case Manager also documented the physician was contacted within one day to resolve any issues found. Patient #13's record contained a medication interaction detail report, dated 11/24/14, listing the following medication interactions:</p> <p>- A severity level of "major" was identified between Simvastatin (a cholesterol medication) and multivitamin. The warning stated that taking these medications concurrently may result in myopathy (a neuromuscular disorder).</p>	G 337			

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G 337	Continued From page 85 - A severity level of "major" was identified between Venlafaxine (an antidepressant) and Trazodone (a medicine used frequently to treat insomnia). The warning stated taking these medications concurrently may result in Serotonin syndrome. - A severity level of "moderate" was identified between Calcium and Hydrochlorothiazide. The warning stated that taking these medications concurrently may result in high calcium levels. The Mayo Clinic website, accessed 1/06/15, stated high calcium levels may cause kidney stones or abnormal heart rhythms. - A severity level of "moderate" was identified between Calcium and Levothyroxine (a medicine used to treat thyroid problems). The warning stated that taking these medications concurrently may disrupt the effectiveness of the thyroid medication. - A severity level of "moderate" was identified between Glimepiride and Januvia (both medications are used to treat diabetes). The warning stated that taking these medications concurrently may result in low blood sugar levels. - A severity level of "moderate" was identified between Levothyroxine and Simvastatin. The warning stated that taking these medications concurrently may decrease the effectiveness of the Levothyroxine. - A severity level of "moderate" was identified between Glimepiride and Levothyroxine. The warning stated that taking these medications concurrently may decrease effectiveness of the diabetic medication.	G 337		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2014
NAME OF PROVIDER OR SUPPLIER TOUCHMARK HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 210 SOUTH TOUCHMARK WAY MERIDIAN, ID 83642		
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G 337	<p>Continued From page 86</p> <p>During an interview on 12/22/14 at 9:55 AM, the RN Case Manager reviewed the SOC assessment and record. She confirmed she documented no problems were found during the medication review. The RN Case Manager confirmed the medication interaction report was not generated until 11/24/14, 11 days after the SOC assessment visit was made. She stated Patient #13's physician was contacted regarding the interactions, but she could not confirm that he was contacted within 1 calendar day as documented in the SOC assessment.</p> <p>Patient #13's medication review was not accurate.</p> <p>7. Patient #8 was a 71 year old male admitted to the agency on 10/19/14, for treatment of decubitus ulcers. Additional diagnoses included non-surgical wound dressing changes, diabetes type II, long-term insulin use, and dementia. He received SN and PT services. His record, including the POC, for the certification period 10/19/14 to 12/17/14, was reviewed.</p> <p>The SOC assessment was completed on 10/19/14, by the RN Case Manager. The assessment documented no problems were found during Patient #8's medication review. Patient #8's record contained a medication interaction detail report, dated 10/20/14, listing the following medication interactions:</p> <p>- A severity level of "major" was identified between Quetiapine Fumarate and Risperidone (both medications are used to treat psychiatric</p>	G 337			

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G 337	<p>Continued From page 87 disorders). The warning stated that taking these medications concurrently may cause a life threatening abnormal heart rhythm.</p> <p>- A severity level of "major" was identified between Clonazepam (a medication used to treat anxiety) and Hydrocodone- APAP a pain medication. The warning stated that taking these medications concurrently may cause respiratory depression.</p> <p>- A severity level of "moderate" was identified between Aspirin and Humalog. The warning stated taking these medications concurrently may cause low blood glucose levels.</p> <p>- A severity level of "moderate" was identified between Aspirin and Lisinopril. The warning stated taking these medications concurrently may decrease the effectiveness of the blood pressure medication.</p> <p>- A severity level of "moderate" was identified between Divalproex Sodium (a medication used to treat seizures and some psychiatric disorders) and Risperidone. The warning stated taking these medications concurrently may increase the levels of the Divalproex Sodium in the blood.</p> <p>During an interview on 12/17/14 beginning at 12:00 PM, the RN Case Manager reviewed the record and confirmed she answered the medication interaction question incorrectly. Additionally, she stated, the office runs the interactions and faxes the results to the physician.</p> <p>Patient #8's SOC medication reconciliation was not complete and accurate.</p>	G 337		

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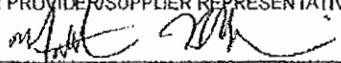
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001660	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/22/2014
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N 000	<p>16.03.07 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the recertification survey of your home health agency completed 12/15/14 through 12/22/14. Surveyors conducting the recertification were:</p> <p>Don Sylvester, RN, HFS, Team Leader Laura Thompson, RN, HFS Sylvia Creswell, LSW, HFS, Supervisor</p> <p>The following acronyms were used in this report:</p> <p>CAD - Coronary Artery Disease CNA - Certified Nursing Assistant DM - Diabetes Mellitus HHA - Home Health Aide HTN - Hypertension OT - Occupational Therapist POC - Plan of Care PT - Physical Therapist Pt - Patient RN - Registered Nurse ROC - Resumption of Care SN - Skilled Nurse SOC - Start of Care ST - Speech Therapist TED Hose- Thromb Embolic Deterrent stockings</p>	N 000	<p style="text-align: center;">RECEIVED JAN 22 2015 FACILITY STANDARDS</p>	
N 001	<p>03.07020.01. ADMIN.GOV.BODY</p> <p>020. ADMINISTRATION - GOVERNING BODY.</p> <p>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.</p>	N 001		

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



TITLE

Administrator

(X6) DATE

1/22/15

Bureau of Facility Standards

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N 001	Continued From page 1 This Rule is not met as evidenced by: Refer to G128 as it relates to the failure of the Governing Body to assume responsibility for the conduct of the agency.	N 001		
N 003	03.07020.03.ADMIN.GOV.BODY N003 03.Responsibilities. The governing body shall assume responsibility for: This Rule is not met as evidenced by: Refer to G128, as it relates to the failure of the governing body (or designated persons so functioning)to assume full legal authority and responsibility for the operation of the agency.	N 003	N003 ADMIN. GOV. BODY Please see response for G128	
N 007	03.07020. ADMIN. GOV. BODY N007 03. Responsibilities. The governing body shall assume responsibility for: d. Providing a continuing and annual program of overall agency evaluation. This Rule is not met as evidenced by: Refer to G128, as it relates to the failure of the governing body (or designated persons so functioning)to assume full legal authority and responsibility for the operation of the agency and provide a continuing annual program of overall agency evaluation.	N 007	N007 ADMIN. GOV. BODY Please see response for G128	
N 026	03.07020. ADMIN. GOV. BODY N026 04. Patients' Rights. Insure	N 026		

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N 026	Continued From page 2 that patients' rights are recognized and include as a minimum the following: d.viii. The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA and must document both the existence of the complaint and the resolution of the complaint. This Rule is not met as evidenced by: Refer to G107 as it relates to the failure of the agency to investigate complaints.	N 026	N026 ADMIN. GOV. BODY Please see response for G107	
N 046	03.07021.02.ADMINISTRATOR N046 02. Absences. The administrator shall designate, in writing, a qualified person to perform the functions of the administrator to act in his absence. This Rule is not met as evidenced by: Refer to G137 as it relates to the agency's failure to have in writing, a qualified person to perform the functions of the administrator in his absence.	N 046	N046 ADMINISTRATOR Please see response for G137	
N 066	03.07021. ADMINISTRATOR N066 03.Responsibilities. The administrator, or his designee, shall assume responsibility for: I. Conducting an annual	N 066	N066 ADMINISTRATOR Please see response for G128	

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N 066	Continued From page 3 evaluation and maintaining documentation of reports and communications to the governing body. This Rule is not met as evidenced by: Refer to G128 as it relates to the agency's failure to conduct an annual evaluation and maintain documentation of reports and communications to the governing body.	N 066		
N 067	03.07021. ADMINISTRATOR N067 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: m. Directing investigations by the agency of complaints against the agency or agency personnel. This Rule is not met as evidenced by: Refer to G107 as it relates to the agency's failure to ensure the administrator, or his designee, assumes responsibility for directing investigations by the agency of complaints against the agency or agency personnel.	N 067	N067 ADMINISTRATOR Please see response for G107	
N 071	0307022.02.DIRECTOR N071 02. Responsibilities. The director or designee shall be responsible for assuring that: a. An initial assessment/evaluation is made to provide a data base to plan and initiate care of the patient; This Rule is not met as evidenced by:	N 071	N071 DIRECTOR Please see response for G171 and G331	

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NAME OF PROVIDER OR SUPPLIER TOUCHMARK HOME HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 210 SOUTH TOUCHMARK WAY MERIDIAN, ID 83842
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N 071	Continued From page 4 Refer to G171 and G331 as it relates to the agency's failure to assure an initial assessment/evaluation is made to provide a data base to plan and inlltate care of the patient.	N 071		
N 074	03.07022. DIRECTOR N074 02. Responsibilities. The director or designee shall be responsible for assuring that: d. The initial plan of treatment and subsequent changes are approved by signature of the attending physician and carried out according to his direction. This Rule is not met as evidenced by: Refer to G171 as it relates to the agency's failure to ensure the initial plan of treatment and subsequent changes are approved by signature of the attending physician and carried out according to his direction.	N 074	074 DIRECTOR Please see response for G171	
N 076	03.07022. DIRECTOR N076 02. Responsibilities. The director or designee shall be responsible for assuring that: f. Information is available to the attending physician on an ongoing basis and is timely, accurate, and significant of change in clinical status or condition; This Rule is not met as evidenced by: Refer to G164 as it relates to the Agency's failure to ensure accurate information (including	N 076	N076 DIRECTOR Please see response for G164	

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N 076	Continued From page 5 significant changes in clinical status) was available to the attending physician on an ongoing basis.	N 076		
N 088	03.07023. POL.& PROC. MAN. N088 02. Contents. The manual will, at a minimum, include policies and procedures reflecting the: j. Audit of clinical records for medical, nursing, and other services; This Rule is not met as evidenced by: Refer to G128 and G250 as it relates to failure of the agency to complete clinical record audits.	N 088	N088 POL. & PROC. MAN. Please see response for G128 and G250	
N 091	03.07024. SK.NSG.SERV. N091. The HHA furnishes nursing services by or under the supervision of a registered nurse in accordance with the plan of care. This Rule is not met as evidenced by: Refer to G170 as it relates to the failure of the agency to furnish nursing services in accordance with the plan of care.	N 091	N091 SK. NSG. SERV. Please see response for G170	
N 093	03.07024. SK. NSG. SERV. N093 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following:	N 093	N093 SK. NSG. SERV. Please see response for G171 and G335	

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N 093	Continued From page 6 a. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs; This Rule is not met as evidenced by: Refer to G171 and G335 as it relates to the failure of the agency to ensure a comprehensive assessment was completed for all patients and that an RN made the initial assessment visit.	N 093		
N 094	03.07024. SK. NSG. SERV. N094 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: b. Initiates the plan of care and makes necessary revisions; This Rule is not met as evidenced by: Refer to G170 as it relates to the failure of the agency to initiate the plan of care and make necessary revisions.	N 094	N094 SK. NSG. SERV Please see response for G170	
N 098	03.07024. SK. NSG. SERV. N098 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following:	N 098	N098 SK. NSG. SERV. Please see response for G164	

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N 098	Continued From page 7 f. Informs the physician and other personnel of changes in the patient's condition and needs; This Rule is not met as evidenced by: Refer to G164 as it relates to the agency's failure to inform the physician of changes in the patient's condition and needs.	N 098		
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 care followed a written plan of care.	N 152	N152 PLAN OF CARE Please see response for G158	
N 153	03.07030.PLAN OF CARE N153 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: a. All pertinent diagnoses; This Rule is not met as evidenced by: Refer to G159 as it relates to the failure of the agency to ensure the plan of care covered all	N 153	N153 PLAN OF CARE Please see response for G159	

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N 153	Continued From page 8 pertinent diagnoses.	N 153		
N 172	03.07030.06.PLAN OF CARE N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This Rule is not met as evidenced by: Refer to G164 as it relates to the failure of the agency to ensure professional staff promptly alerted the physician to any changes that suggested a need to alter the plan of care.	N 172	N172 PLAN OF CARE Please see response for G164	
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to G337 as it relates to the failure of the agency to ensure agency staff check all medications a patient may be taking to identify possible side effects, drug allergies, and contraindicated medication and promptly report any problems to the physician.	N 173	N173 PLAN OF CARE Please see response for G337	

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N 174	03.07031.01 CLINICAL RECORDS N174 01. Purpose. A clinical record containing past and current findings, in accordance with accepted professional standards, is maintained for every patient receiving home health services. This Rule is not met as evidenced by: Refer to G236 as it relates to the failure of the agency to ensure a clinical record was maintained in accordance with accepted professional standards for all patients.	N 174	N174 CLINICAL RECORDS Please see response for G236	
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 G155.	N 193	N193 AGENCY EVALUATION Please see response for G155	
N 195	03.07040.02 AGENCY EVAL. N195 02. Evaluation Criteria and	N 195		

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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) COMPLETE DATE
N 195	<p>Continued From page 10</p> <p>Purpose. The evaluation consists of an overall policy and administrative review and a clinical record review and assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient.</p> <p>This Rule is not met as evidenced by: Refer to G245 as it relates to the failure of the agency to ensure an agency evaluation was conducted that assessed the extent to which the agency's program was appropriate, adequate, effective, and efficient.</p>	N 195	<div style="border: 1px solid black; padding: 5px;"> <p>N195 AGENCY EVAL. Please see response for G245</p> </div>	
N 196	<p>03.07040.03 AGENCY EVAL.</p> <p>N196 03. Evaluation Results. Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.</p> <p>This Rule is not met as evidenced by: Refer to G244 as it relates to the agency's failure to have annual evaluation results reported and acted upon.</p>	N 196	<div style="border: 1px solid black; padding: 5px;"> <p>N196 AGENCY EVAL. Please see response for G244</p> </div>	
N 197	<p>03.07050. CINICAL REC. REVIEW</p> <p>N197 050. CLINICAL RECORD REVIEW. The agency shall have a subcommittee to perform an audit of clinical records on at least a quarterly basis to determine the adequacy of services provided in meeting patient's needs. The committee members will represent the scope of the program consisting of health professionals. The review shall</p>	N 197	<div style="border: 1px solid black; padding: 5px;"> <p>N197 CLINICAL REC. REVIEW Please see response for G250</p> </div>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OAS001660	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2014	
NAME OF PROVIDER OR SUPPLIER TOUCHMARK HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 210 SOUTH TOUCHMARK WAY MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETE DATE
N 197	<p>Continued From page 11</p> <p>consist of at least ten per cent (10%) sampling of both active and closed clinical records representing all services being offered. A written summary of findings and recommendations of the committee shall be utilized in the overall review and self-evaluation of the agency.</p> <p>This Rule is not met as evidenced by: Refer to G250 as it relates to the agency's failure to perform an audit of 10% of clinical records on at least a quarterly basis.</p>	N 197		