DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS 400
Seattle, WA 98104

Western Division of Survey and Certification

October 31, 2018

Abode Home Health - Boise
2090 S Eagle Road
Meridian, ID 83642-3597

CMS Certification Number: 137123

Re: Results of Sample Validation Survey

Dear Administrator:

The Centers for Medicare and Medicaid Services (CMS) is confirming the results of the sample validation survey, completed by the at Abode Home Health - Boise. Enclosed you will find the results of your Health and Life Safety Code surveys (CMS Form 2567).

CMS finds that your facility is in compliance with all the Medicare Conditions of Participation and will continue to be certified as meeting Medicare requirements. We have forwarded a copy of this letter and the findings from the survey to the accrediting organization, CHAP.

It is not a requirement to submit a plan of correction; **if you choose to not submit a plan a correction, please sign and date the first page of the Form CMS-2567 and return to** Bureau Of Facility Standards (State survey agency):

Debby Ransom
Bureau of Facility Standards
PO Box 83720
Boise, ID 83720

Under federal disclosure rules, findings of the inspection, including the plan of correction submitted by the facility, become publicly disclosable (if requested) within ninety days (90 days) of completion.

Therefore, if you wish to submit your plans for correcting the standard deficiencies cited on the CMS 2567, please do so within 10 days of the receipt of this letter. Plans of Corrections must contain the following elements:

- The plan for correcting each specific deficiency cited;
- The plan should address improving 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;
- All plans of correction must demonstrate how the facility has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

We thank you for your cooperation, and look forward to working with you on a continuing basis in the administration of the Medicare program. All correspondence and questions should be directed to CMS_RO10_CEB@cms.hss.gov, Attn: CHAP

Sincerely,

Julius P. Bunch Jr.
Branch Manager – (CQISCO)
Certification & Enforcement Branch

Enclosure(s)

cc: Bureau Of Facility Standards
Office of the State Fire Marshal
CMS Central Office
CHAP

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137123	A. BUILDING _____ B. WING _____	10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABODE HOME HEALTH - BOISE	2090 S EAGLE ROAD 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 Medicare validation survey of your agency conducted on 10/15/18 to 10/18/18. Surveyors conducting the validation survey were: Brian Osborn, RN, HFS, Team Lead James Brown, RN, HFS Acronyms used in this report include: CHF - Congestive Heart Failure CNA - Certified Nursing Assistant COPD - Chronic Obstructive Pulmonary Disease DM - Diabetes Mellitus HTN - Hypertension ICD - International Statistical Classification of Diseases and Related Health Problems MSW - Medical Social Worker OT - Occupational Therapist PCS - Personal Care Services PDSA - Plan Do Study Act PIP - Performance Improvement Project POA - Power of Attorney POC - Plan of Care PT - Physical Therapy pt - patient PTA - Physical Therapy Assistant QI - Quality Indicator RN - Registered Nurse RNCM - Registered Nurse Case Manager SOC - Start of Care SN - Skilled Nursing VAD - Vascular Access Device	G 000	RECEIVED NOV - 8 2018 FACILITY STANDARDS	
G 434	Participate in care CFR(s): 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or	G 434	**What action will we take to correct the deficiency cited?** On 10/25/18, the Administrator conducted a training session with staff members on	10/25/18

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

[signature] RN, CHPN, Director of Clinical Operations 11/5/2018

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

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G 434	Continued From page 1 refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. This ELEMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure appropriate consent or refusal of care in advance of treatment for 1 of 4 patients (Patient #10), whose care was observed and whose record was reviewed. This had the potential for patients to not be fully informed of what they were consenting to. Findings include: Patient #10 was a 90 year old female who was admitted to the agency on 9/19/18, with a primary diagnosis of venous insufficiency. Additional diagnoses included CHF and Alzheimer's. She received SN and PT services. Her record, including the POC, for the certification period 9/19/18 to 11/17/18, was reviewed. Patient #10's medical record included an POC,	G 434	appropriate consent and/or refusal of care in advance of treatment. Patient's whom have a diagnosis with potential or identified cognitive impairments will have an authorized representative present when completing the comprehensive assessment and development of the plan of care, as well as any subsequent discussions pertaining to changes in the plan of care. The identified authorized representative present will be documented in the medical record. **Who is responsible to implement the corrective action?** Administrator **When will the corrective action be implemented?** October 25, 2018 **What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?** Beginning 11/5/18, the Administrator and Clinical Supervisor will review all referral documentation in advance to determine if the client requires an authorized representative present during the comprehensive assessment and admission process and coordinate accordingly. For any subsequent plan of care changes, clinicians will coordinate with the authorized representative, ensuring appropriate consent or refusal of care. The Administrator will review 100% of referral documentation and plan of care changes meeting a 100% threshold for three consecutive months validating appropriate	

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G 434	Continued From page 2 dated 9/18/18, signed by her physician. The POC included "ICD-10 Diagnoses...ALZHEIMER'S DISEASE WITH LATE ONSET." Patient #10's medical record included a SOC comprehensive assessment, dated 9/19/18, signed by the RNCM, which stated: "1 - MEMORY DEFICIT: FAILURE TO RECOGNIZE FAMILIAR PERSONS/PLACES, INABILITY TO RECALL EVENTS OF PAST 24 HOURS, SIGNIFICANT MEMORY LOSS SO THAT SUPERVISION IS REQUIRED [sic] 2 - IMPAIRED DECISION-MAKING: FAILURE TO PERFORM USUAL ADLS OR IADLS, INABILITY TO APPROPRIATELY STOP ACTIVITIES, JEOPARDIZES SAFETY THROUH ACTIONS [sic]" A PTA home visit was observed in Patient #10's residence on 10/16/18, beginning at 10:27 AM. When the PTA was asked if Patient #10 was cognitively able to understand and sign her own consents, she stated "I don't think she is able to sign consents due to her Alzheimer's." During the home visit, Patient #10 was observed to have frequent moments of forgetfulness and confusion and needed constant cueing to focus and stay on task with the PTA's instructions. Patient #10's medical record included a "CONSENT FOR TREATMENT AND AUTHORIZATION FOR PAYMENT TO PROVIDER," signed by the RNCM. The consent was signed by Patient #10, not by her POA or representative. It was unclear how Patient #10 signed her consent for treatment with her identified cognitive issues.	G 434	consent and/or refusal of care. If that goal is not met, monitoring of 100% will continue for each additional month until the goal of 100% threshold is met. Afterward, to ensure on-going compliance, an audit will occur on a Quarterly basis for three consecutive Quarters of 100% of referral documentation and Plan of Care changes until the threshold of success is demonstrated at 100%. If at any time, during the random Quarterly Audits, the audit findings drop below 100%, the random audit frequency will increase to Monthly with a sample size increase to 75%. The Agency's threshold must meet a total of 100% for three consecutive audits prior to recommendation to remove the audit from the QAPI Audit schedule. The results of the audit will be reported to the QAPI Committee for discussion, revision, or completion based on the Committee's determination that the threshold has been met as outlined and demonstrated through on-going compliance. The QAPI committee with report non-compliant monitoring finding to the Governing Body.	

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G 434	Continued From page 3 The Director of Compliance was interviewed on 10/17/18, beginning at 9:37 AM, and Patient #10's medical record was reviewed in her presence. She confirmed it was unclear if Patient #10's documented cognitive issues precluded her from signing her own legal consents. The agency failed to ensure appropriate consent or refusal of care in advance of treatment for Patient #10.	G 434		
G 464	Advise the patient of discharge for cause CFR(s): 484.50(d)(5)(i) Advise the patient, representative (if any), the physician(s) issuing orders for the home health plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) that a discharge for cause is being considered; This ELEMENT is not met as evidenced by: Based on review of medical records, and staff interview, it was determined the agency failed to ensure the patient's primary care practitioner was notified in advance that a discharge for cause was being considered for 1 of 1 patient (Patient #2) who was discharged for cause and whose record was reviewed. This resulted in a lack of opportunity for the primary care physician to intervene or adjust the plan of care to address problematic behavior. Findings include: Patient #2 was a 32 year old male who was admitted on 6/14/18, with a primary diagnosis of DM Type 1. Additional diagnoses included bipolar disorder, anxiety, and falls. He received SN and PT services. His record, including the	G 464	**What action will we take to correct the deficiency cited?** On 10/25/18, the Administrator conducted a training session with staff members on Agency Policy and Procedure HH:2-053 "DISCHARGE CRITERIA AND PROCESS". When considering discharge for cause, the physician(s) will be contacted and notified of circumstances prompting the discharge for cause. Evidence of this discussion will be present in the medical record. **Who is responsible to implement the corrective action?** Administrator **When will the corrective action be implemented?** October 25, 2018 **What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?** Beginning 11/5/18, to monitor the implementation plan and effectiveness	10/25/18

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G 464	Continued From page 4 POC, for the certification periods 6/14/18 to 8/12/18 and 8/13/18 to 10/11/18 was reviewed. Patient #2's medical record included a physician order, dated 9/06/18, signed by his physician, which stated "PT TO BE DISCHARGED FROM HOME HEALTH SERVCIES AS PT AND FAIMLY HAVE BEEN UNABLE TO FOLLOW THE PLAN OF CARE DEVELOPED BY SKILLED NURSING, PHYSICAL THERAPY, AND OCCUPATIONAL THERAPY. DISCHARGE TO BE COMPLETED THURSDAY, 9/6/18." Patient #2 was discharged from the agency on 9/06/18. It was not documented Patient #2's physician was notified that a discharge for cause was being considered prior to the day he was discharged from agency services. The Director of Compliance was interviewed on 10/17/18, beginning at 9:37 AM, and Patient #2's medical record was reviewed in her presence. She confirmed agency staff did not document that a discharge for cause was being considered by Patient #2's physician prior to his discharge from agency services. The agency failed to ensure Patient #2's physician was notified in advance that a discharge for cause was being considered.	G 464	of the corrective action plan, the Administrator will complete an audit of 100% of medical records when a discharge for cause is considered meeting a threshold of 100% for three consecutive months to ensure appropriate documentation is evident validating discussion with the physician(s). If that goal is not met, monitoring of 100% will continue for each additional month until the goal of 100% threshold is met. Afterward, to ensure on-going compliance, an audit will occur on a Quarterly basis for three consecutive Quarters of 50% of medical records when a discharge for cause is considered until the threshold of success is demonstrated at 100%. If at any time, during the random Quarterly Audits, the audit findings drop below 100%, the random audit frequency will increase to Monthly with a sample size increase to 75%. The Agency's threshold must meet a total of 100% for three consecutive audits prior to recommendation to remove the audit from the QAPI Audit schedule. The results of the audit will be reported to the QAPI Committee for discussion, revision, or completion based on the Committee's determination that the threshold has been met as outlined and demonstrated through on-going compliance. The QAPI committee with report non-compliant monitoring finding to the Governing Body.	
G 468	Provide contact info other services CFR(s): 484.50(d)(5)(iii) (iii) Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and	G 468	**What action will we take to correct the deficiency cited?** On 10/25/18, the Administrator conducted a training session with staff members on Agency Policy and Procedure HH:2-053 "DISCHARGE CRITERIA AND PROCESS".	10/25/18

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G 468	Continued From page 5 This ELEMENT 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 patients were provided contact information for other agencies or providers who may be able to provide care for 1 of 1 patient (Patient #2) who was discharged for cause and whose record was reviewed. This had the potential for unmet patient needs and breakdown in continuity of patient care. An agency policy "DISCHARGE CRITERIA AND PROCESS," revised 6/2018, stated "5. The decision to terminate or reduce services must be documented in the clinical record citing the circumstances and notification to the patient, the responsible family/caregiver or representative, and the patient's physician. Efforts to resolve problems prior to discharge will also be documented in the patient's record. The patient will be provided contact information for other home health agencies and providers if continued care is needed." This policy was not followed. Patient #2 was a 32 year old male who was admitted on 6/14/18, with a primary diagnosis of DM Type 1. Additional diagnoses included bipolar disorder, anxiety, and falls. He received SN and PT services. His record, including the POC, for the certification periods 6/14/18 to 8/12/18 and 8/13/18 to 10/11/18 was reviewed. Patient #2's medical record included a "Home Health Change of Care Notice (HHCCN)," undated, signed by a CNA. The form included: "Your home health agency has decided to stop giving you the home care listed above. You can look for care from a different home health agency	G 468	When considering discharge for cause, the patient will be provided with contact information for other home health agencies and providers if continued care is needed. **Who is responsible to implement the corrective action?** Administrator **When will the corrective action be implemented?** October 25, 2018 **What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?** Beginning 11/5/18, to monitor the implementation plan and effectiveness of the corrective action plan, the Administrator will complete an audit of 100% of medical records when a discharge for cause is considered meeting a threshold of 100% for three consecutive months to ensure appropriate documentation is evident validating the patient has been provided contact information for other home health agencies and providers. If that goal is not met, monitoring of 100% will continue for each additional month until the goal of 100% threshold is met. Afterward, to ensure on-going compliance, an audit will occur on a Quarterly basis for three consecutive Quarters of 50% of medical records when a discharge for cause is considered until the threshold of success is demonstrated at 100%. If at any time, during the random Quarterly Audits, the audit findings drop below 100%, the random audit frequency	

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G 468	Continued From page 6 if you have a valid order for home care and still think you need home care. If you need help finding a different home health agency to give you this care, contact the doctor who ordered your home care." The form did not include contact information for other agencies or providers who may be able to provide care to Patient#2. The Director of Compliance was interviewed on 10/17/18, beginning at 9:37 AM, and Patient #2's medical record was reviewed in her presence. She confirmed agency staff did not document contact information for other agencies or providers who may be able to provide care to Patient #2. The agency failed to ensure Patient #2 was provided contact information for other agencies or providers who may be able to provide care.	G 468	will increase to Monthly with a sample size increase to 75%. The Agency's threshold must meet a total of 100% for three consecutive audits prior to recommendation to remove the audit from the QAPI Audit schedule. The results of the audit will be reported to the QAPI Committee for discussion, revision, or completion based on the Committee's determination that the threshold has been met as outlined and demonstrated through on-going compliance. The QAPI committee with report non-compliant monitoring finding to the Governing Body.	
G 484	Document complaint and resolution CFR(s): 484.50(e)(1)(ii) Document both the existence of the complaint and the resolution of the complaint; and This ELEMENT is not met as evidenced by: Based on review of medical records, agency policy, observation, grievance and complaint logs, and staff interview, it was determined the agency failed to ensure the existence of complaints, and their resolutions, were documented for 2 of 10 patients (#2 and #7) whose records were reviewed. This had the potential for patients' concerns with care delivery not being investigated by agency staff. Findings include: An agency policy "COMPLAINT/GRIEVANCE	G 484	**What action will we take to correct the deficiency cited?** On 10/25/18, the Administrator conducted a training session with staff members on Agency Policy and Procedure C:2-007 "Complaint/Grievance Process". Organization staff members receiving the complaint will discuss, verbally and in writing, the grievance with a supervisor within five days of the alleged grievance. **Who is responsible to implement the corrective action?** Administrator **When will the corrective action be implemented?** 10/25/2018	10/25/18

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G 484	Continued From page 7 PROCESS," revised 6/2017, stated "The organization staff member receiving the complaint will discuss, verbally and in writing, the grievance with a supervisor within five (5) days of the alleged grievance." This policy was not followed. 1. Patient #2 was a 32 year old male who was admitted on 6/14/18, with a primary diagnosis of DM Type 1. Additional diagnoses included bipolar disorder, anxiety, and falls. He received SN and PT services. His record, including the POC, for the certification periods 6/14/18 to 8/12/18 and 8/13/18 to 10/11/18 was reviewed. The agency failed to ensure the documented existence and resolution of Patient #2's complaints. Examples include: a. Patient #2's medical record included a "Client Coordination Notes Report," dated 9/05/18, signed by an Occupational Therapist, which stated "Patient's mother was very vocal about the fact that she feels that therapy is giving up on her son and does not agree with therapy discharge." The agency's grievance log, undated, was reviewed. The existence and resolution to this complaint was not documented. b. Patient #2's medical record included a "Client Coordination Notes Report," dated 9/06/18, signed by the RNCM, which stated "Patient's mother was very vocal about the fact that she feels that therapy is giving up on her son and does not agree with therapy discharge." The agency's grievance log, undated, was reviewed. The existence and resolution to this complaint was not documented.	G 484	**What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?** Beginning 11/5/18, to monitor the implementation plan and effectiveness of the corrective action plan, the Administrator will complete a daily audit of 100% of coordination notes meeting a threshold of 100% for three consecutive months to ensure any alleged grievance is addressed within five days. If that goal is not met, monitoring of 100% will continue for each additional month until the goal of 100% threshold is met. Afterward, to ensure on-going compliance, an audit will occur on a Quarterly basis for three consecutive Quarters of 50% of all coordination notes until the threshold of success is demonstrated at 100%. If at any time, during the random Quarterly Audits, the audit findings drop below 100%, the random audit frequency will increase to Monthly with a sample size increase to 75%. The Agency's threshold must meet a total of 100% for three consecutive audits prior to recommendation to remove the audit from the QAPI Audit schedule. The results of the audit will be reported to the QAPI Committee for discussion, revision, or completion based on the Committee's determination that the threshold has been met as outlined and demonstrated through on-going compliance. The QAPI committee with report non-compliant monitoring finding to the Governing Body.	

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G 484	Continued From page 8 c. Patient #2's medical record included a "Client Coordination Notes Report," dated 9/06/18 for a late entry on 9/11/18, signed by the MSW, stated "[Patient #2's mother's name] states that she feels like Abode staff are 'giving up' on [Patient #2]." The agency's grievance log, undated, was reviewed. The existence and resolution to this complaint was not documented. The Director of Compliance was interviewed on 10/17/18, beginning at 9:37 AM, and Patient #2's medical record was reviewed in her presence. She confirmed agency staff did not document the existence and resolution of identified complaints. The agency failed to ensure the existence of complaints, and their resolutions, were documented for Patient #2. 2. Patient #7 was a 93 year old male admitted to the agency on 8/24/18, with a primary diagnosis of abnormalities of gait and mobility. Additional diagnoses included malignant neoplasm of bone, and unspecified dementia. He received PT and Aide services. His record, including the POC for the certification period of 8/24/18 to 10/22/18, was reviewed. A home visit was conducted 10/16/18, beginning at 11:00 AM, to observe the home health aide for Patient #7. During the visit Patient #7's caregiver voiced a concern to this surveyor about the aide not coming on 10/19/18 because Patient #7 was being discharged on 10/17/18. The caregiver stated she was told the aide was coming on 10/19/18, and she had set up PCS next week to start on Tuesday. She stated she was upset she	G 484		

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G 484	Continued From page 9 would be without an aide the rest of the week. When asked if the caregiver had notified the Case Manager about her complaints, she stated she notified her "last week" and again on 10/15/18. The Case Manager, who was a Physical Therapist, was interviewed on 10/17/18, beginning at 2:30 PM. When asked if Patient #7's caregiver had voiced her complaints to her about the loss of the bath aide, the Case Manager stated she spoke with Patient #7's caregiver on 10/15/18 she was upset. When asked if she entered a complaint about the caregiver's issue, she stated she had not at this time. The Director of Compliance was interviewed on 10/17/18, beginning at 2:55 PM. She stated it was the expectation that complaints and grievances would be entered immediately upon receiving it, and the Case Manager should have entered the complaint. The Director of Compliance was interviewed on 10/18/18, at 10:45 AM. When asked if the Case Manager had entered the complaint from Patient #7's caregiver a complaint or grievance into the system, she stated the Case Manager had not. The agency failed to ensure all complaints and grievences were documented.	G 484		
G 574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) (2) The individualized plan of care must include the following:	G 574	**What action will we take to correct the deficiency cited?** On 10/25/18, the Administrator conducted a training session with staff members on Agency Policy HH:2-004 "Care Planning Process". A written plan of care will be initiated within five (5) days of start of care	10/25/18

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

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	137123	A. BUILDING _____ B. WING _____	10/18/2018

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G 574	Continued From page 10 (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. This ELEMENT is not met as evidenced by: Based on review of medical records and staff interview, it was determined the agency failed to ensure the POC was accurate and included all pertinent medications, interventions, and goals for 2 of 10 patients (#1 and #6) whose records were reviewed. This resulted in incomplete POCs and had the potential to result in unmet patient needs. Findings include: 1. Patient #1 was a 66 year old male who was admitted to the agency on 1/03/18, with a primary	G 574	and updated at least every 60 days or as a patient's condition warrants. The patient plan of care will be developed or revised within five (5) working days of initiation of each service or of the reassessment of the patient. The plan of care will include all medications, nutritional risk, and appropriate interventions and goals to address identified nutritional risk. **Who is responsible to implement the corrective action?** Administrator **When will the corrective action be implemented?** October 25, 2018 **What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?** Beginning 11/5/2018, to monitor the implementation plan and effectiveness of the corrective action plan, the Administrator will complete an audit of 100% of each plan of care and coordination notes, meeting a threshold of 100% for three consecutive months, validate all medications, nutritional risk, and interventions and goals are present. If that goal is not met, monitoring of 100% will continue for each additional month until the goal of 100% threshold is met. Afterward, to ensure on-going compliance, an audit will occur on a Quarterly basis for three consecutive Quarters of 50% of plan of care and coordination notes until the threshold of success is demonstrated at 100%. If at any time, during the random Quarterly Audits,	

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G 574	Continued From page 11 diagnosis of brain cancer. Additional diagnoses included epilepsy and depression. He received SN, PT, OT, MSW, and aide services. His record, including the POC, for the certification period 1/03/18 to 3/03/18, was reviewed. Patient #1's medical record included an OT visit note, dated 2/07/18, signed by the Occupational Therapist, which stated "PATIENTS [sic] SPOUSE REPORTS PATIENT HAS [sic] A SEIZURE ON MONDAY EVENING. PATIENT WENT TO DR YESTERDAY AND SHE TOLD PATIENT TO START TAKING ANTI SEIZURE MED THAT [sic] ALREADY HAS." Patient #1's medical record included a POC, dated 1/10/18, signed by a physician. The POC did not include a current or discontinued antiseizure medication. The Director of Compliance was interviewed on 10/17/18, beginning at 10:17 AM, and Patient #1's medical record was confirmed in her presence. She confirmed Patient #1 did not have a documented antiseizure medication listed on his POC. The agency failed to ensure Patient #2's POC was accurate and included all his pertinent medications. 2. Patient #6 was a 69 year old female admitted to the agency on 9/08/18, with a primary diagnosis of aphasia following cerebral infarction. Additional diagnoses included muscle weakness, HTN, and speech language deficits. She received SN, PT, ST and OT services. Her record, including the POC, for the certification period 9/08/18 to 11/06/18, was reviewed.	G 574	the audit findings drop below 100%, the random audit frequency will increase to Monthly with a sample size increase to 75%. The Agency's threshold must meet a total of 100% for three consecutive audits prior to recommendation to remove the audit from the QAPI Audit schedule. The results of the audit will be reported to the QAPI Committee for discussion, revision, or completion based on the Committee's determination that the threshold has been met as outlined and demonstrated through on-going compliance. The QAPI committee with report non-compliant monitoring finding to the Governing Body.	

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G 574	Continued From page 12 Patient #6's record included an SOC comprehensive assessment, dated 9/08/18, signed by the RNCM. The assessment documented "COMMUNITY SERVICES INVOLVED OR NEEDED IN THE PATIENT'S CARE: MEALS ON WHEELS". The RNCM documented that meals on wheels was needed by Patient #6. Under the section titled "NUTRITION", the RNCM documented "PROBABLY INADEQUATE - RARELY EATS A COMPLETE MEAL AND GENERALLY EATS ONLY ABOUT ½ OF ANY FOOD OFFERED". In the section titled "FUNCTIONAL", the RNCM documented "UNABLE TO PREPARE LIGHT MEALS ON A REGULAR BASIS DUE TO PHYSICAL, COGNITIVE, OR MENTAL LIMITATIONS". Patient #6's POC did not include interventions or goals related to her nutritional risk. During an interview on 10/17/18, beginning at 11:00 AM the Director of Compliance reviewed Patient #6's record. She confirmed Patient #6's POC did not include interventions or goals related to her identified nutritional risk.	G 574		
G 608	Patient #6's POC did not include interventions or goals related to her identified nutritional risk. Coordinate care delivery CFR(s): 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. This ELEMENT is not met as evidenced by: Based on medical record review and staff	G 608	**What action will we take to correct the deficiency cited?** On 10/25/18, the Administrator conducted a training session with staff members on Agency policy HH:2-013 "Continuity of Care". Periodic communication between team members concerning the patient's progress and special needs as evidenced in case conference reports and clinical notes. The clinician will be responsible for	10/25/18

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G 608	Continued From page 13 interview, it was determined the agency failed to ensure care was coordinated to meet the needs of the patient for 2 of 10 patients (#1 and #6) whose records were reviewed. This had the potential to result in unmet patient needs. Findings include: 1. Patient #1 was a 66 year old male who was admitted to the agency on 1/03/18, with a primary diagnosis of brain cancer. Additional diagnoses included a VAD and depression. He received SN, PT, OT, MSW, and aide services. His record, including the POC, for the certification period 1/03/18 to 3/03/18, was reviewed. The RNCM failed to coordinate care to meet Patient #1's needs. Examples include: a. Patient #1's medical record included a PT visit note, dated 1/05/18, signed by the Physical Therapist, which stated "PATIENT PRESENTS WITH EDEMA TO THE LEFT LOWER EXTREMITY WHICH HE DID NOT HAVE YESTERDAY. PATIENT NOW HAS HIS LEGS ELEVATED. NOTIFIED NURSING REGARDING THE EDEMA." The RNCM did not document what he did with this information or if Patient #1's physician was notified. b. Patient #1's medical record included an aide visit note, dated 1/12/18, signed by a CNA, which stated "COCCYX AREA APPEARS TO HAVE 2 LARGE OPEN AREAS. REPORTED TO RNCM." The RNCM did not document what he did with this information or if Patient #1's physician was notified. c. Patient #1's medical record included an aide visit note, dated 1/19/18, signed by a CNA, which	G 608	communicating with all personnel caring for the patient including the physician. **Who is responsible to implement the corrective action?** Administrator **When will the corrective action be implemented?** October 25, 2018 **What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?** Beginning 11/5/2018, to monitor the implementation plan and effectiveness of the corrective action plan, the Administrator will complete an audit of 100% of all coordination notes meeting a threshold of 100% for three consecutive months, verifying any identified change in condition or special needs are communicated to physician and appropriate clinician(s). If that goal is not met, monitoring of 100% will continue for each additional month until the goal of 100% threshold is met. Afterward, to ensure on-going compliance, an audit will occur on a Quarterly basis for three consecutive Quarters of 50% of the coordination notes until the threshold of success is demonstrated at 100%. If at any time, during the random Quarterly Audits, the audit findings drop below 100%, the random audit frequency will increase to Monthly with a sample size increase to 75%. The Agency's threshold must meet a total of 100% for three consecutive audits prior to recommendation to remove the audit from the QAPI Audit schedule. The	

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G 608	Continued From page 14 stated "PT APPEARS TO HAVE REDNESS & PEELING IN GROIN AREA. REPORTED TO RNCM." The RNCM did not document what he did with this information or if Patient #1's physician was notified. d. Patient #1's medical record included an aide visit note, dated 1/26/18, signed by a CNA, which stated "PT LEFT BIG TOE BY CUTICAL [sic] APPEARS TO HAVE RED SPOT THAT IS TENDER TO TOUCH. REPORTED TO RNCM." The RNCM did not document what he did with this information or if Patient #1's physician was notified. e. Patient #1's medical record included a PT visit note, dated 2/05/18, signed by the Physical Therapist, which stated "PT WAS CONCERNED REGARDING AN ELEVATED HEART RATE OF 125 BEATS PER MINUTE AS WELL AS AN ELEVATED RESPIRATORY RATE OF 24. THESE VALUES WERE ELEVEATED COMPARED TO PATIENT'S PRIOR RECORDED VALUES. PT PHONE [RNCM] FOR INPUT REGARDING THESE VALUES. RN NOT CONCERNED." The RNCM did not document what he did with this information or if Patient #1's physician was notified. f. Patient #1's medical record included an aide visit note, dated 2/23/18, signed by a CNA, which stated "PT APPEARAS TO HAVE DARK COLORING OUTSIDE THE LENGTH OF LEFT LEG CALF AREA. REPORTED TO RNCM." The RNCM did not document what he did with this information or if Patient #1's physician was notified. The Director of Compliance was interviewed on	G 608	results of the audit will be reported to the QAPI Committee for discussion, revision, or completion based on the Committee's determination that the threshold has been met as outlined and demonstrated through on-going compliance. The QAPI committee with report non-compliant monitoring finding to the Governing Body.	

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G 608	Continued From page 15 10/17/18, beginning at 10:17 AM, and Patient #1's medical record was reviewed in her presence. She confirmed Patient #1's RNCM did not document coordination of care between himself and agency clinicians and physicians. The RNCM failed to ensure care was coordinated to meet the needs of Patient #1. 2. Patient #6 was a 69 year old female admitted to the agency on 9/08/18, with a primary diagnosis of aphasia following cerebral infarction. Additional diagnoses included muscle weakness, HTN, and speech language deficits. She received SN, PT, ST and OT services. Her record, including the POC, for the certification period 9/08/18 to 11/06/18, was reviewed. Patient #6's record included a coordination note dated 9/26/18, signed by the Speech Therapist. The note included "PATIENT CALLED TO NOTIFY CLINICIAN THAT SHE HAS BEEN THROWING UP AND DIARRHEA SINCE 4:00 THIS MORNING". There was no documentation Patient #6's RNCM was notified of this change in condition. During an interview on 10/17/18, beginning at 11:00AM the with the Director of Compliance Patient #6's medical record was reviewed in her presence. She confirmed Patient #6's medical record did not include if the Speech Therapist contacted Patient #6's RNCM. The agency failed to ensure the care for Patient #6 was coordinated through all disciplines.	G 608		
G 658	Performance improvement projects CFR(s): 484.65(d)(1)(2)	G 658	**What action will we take to correct the deficiency cited?**	10/25/18

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G 658	Continued From page 16 Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. This STANDARD is not met as evidenced by: Based on quality document review and staff interview, it was determined the agency failed to ensure performance improvement projects had evidence of measurable progress. This had the potential for incomplete analysis of agency identified problems. Findings include: The agency provided a "Performance Improvement Project PDSA worksheet...Abode Home Health QI: Complaint Reports," dated 4/23/18, approved by the Governing Body. The document included the scope of the PIP, goals, and measures criteria. The document did not include data. The Director of Clinical Operations was interviewed on 10/17/18, beginning at 8:50 AM, and the complaint PIP was reviewed in her presence. When asked if the agency had documented data analysis to show measurable progress with their complaint PIP, she stated no. The Director of Clinical Operations stated, in the 6 months since the PIP started, there was no documented information or progress. The agency failed to ensure performance	G 658	On 10/25/18, the Administrator reviewed and updated the Performance Improvement Plan (PIP) on complaints, to include evidence of measurable progress. **Who is responsible to implement the corrective action?** Administrator **When will the corrective action be implemented?** October 25, 2018 **What is the monitoring process we will put into place to ensure implementation and effectiveness of this corrective action plan?** Beginning 10/25/18, to monitor the implementation plan and effectiveness of the corrective action plan, the Administrator will analyze and record 100% of the number of complaints and follow up per Agency policy. The Administrator will document findings monthly for three consecutive months validating measurable progress. If that goal is not met, monitoring of 100% will continue for each additional month until the goal of 100% threshold is met. The Agency's threshold must meet a total of 100% for three consecutive months prior to recommendation to conclude the PIP. The results of the PIP will be reported to the QAPI Committee for discussion, revision, or completion based on the Committee's determination that the threshold has been met as outlined and demonstrated through on-going compliance. The QAPI committee with report non-compliant monitoring finding to the Governing Body.	

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G 658	Continued From page 17 improvement projects had evidence of measurable progress. Refer to G 484 as it relates to the agency's failure to ensure the existence of complaints, and their resolutions, were documented.	G 658		

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E 000	Initial Comments The Medicare validation survey of your agency, including Emergency Preparedness, was conducted on 10/15/18 to 10/18/18 and was found in substantial compliance for the regulations found in Appendix Z of the State Operations Manual. Surveyors conducting the validation survey were: Brian Osborn, RN, HFS, Team Lead James Brown, RN, HFS	E 000		

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

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.