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

March 12, 2015

Matthew Hoskin, Administrator
Touchmark Home Health
PO Box 764
Meridian, ID 83680

RE: Touchmark Home Health, Provider #137092

Dear Mr. Hoskin:

On March 4, 2015, a follow-up visit of your facility, Touchmark Home Health, was conducted to verify corrections of deficiencies noted during the survey of December 22, 2014.

We were able to determine that the Conditions of Participation of **Organization, Services and Administration (42 CFR 484.14), Acceptance of Patients, Plan of Care and Medical Surpervision (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)** are now met.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

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

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;

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

After you have completed your Plan of Correction, return the original to this office by **March 25, 2015**, and keep a copy for your records.

Thank you for the courtesies extended to the surveyors during their visit. If we can be of any help to you, please call us at (208) 334-6626, option 4.

Sincerely,

DON SYLVESTER
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

DS/pmt
Enclosures
ec: Fe Yamada, 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	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	R 03/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	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	{G 000}		

The following deficiencies were cited during the follow up survey of your home health agency completed 3/03/15 through 3/04/15. Surveyors conducting the review were:

Don Sylvester, RN, HFS, Team Lead
Laura Thompson, RN, HFS

Acronyms used in this report include:

CKD - Chronic Kidney Disease
DM - Diabetes Mellitus
HHA - Home Health Aide
mcg - micrograms
meq - milliEquivalent
mg - milligrams
OT - Occupational Therapist
POC - Plan of Care
PT - Physical Therapist
PRN - as needed
QT interval prolongation - a measure of time between the start and end of the heart's electrical cycle
RN - Registered Nurse
SOC - Start of Care
SN - Skilled Nurse

{G 337}	484.55(c) DRUG REGIMEN REVIEW	{G 337}	The comprehensive assessment will 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, (cont. page 2)	03/25/2015

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:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Boender	Home Health Director	3/25/15

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.

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{G 337}	Continued From page 1 Based on record review, policy review, and staff interview it was determined the facility failed to ensure a comprehensive drug regimen review for 5 of 7 patients (#1, #2, #3, #5, and #7) whose records were reviewed. This failure 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" undated, 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 medication changes, and documented on the medication profile, as well as in the visit note. The agency policy, number 9.3.1 "Drug Interaction Identification and Physician Notification" undated, stated "Upon admission to the agency, all patient medications will have a drug interaction summary report, and [it] 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." During an interview on 3/03/15 at 2:35 PM, the Clinical Director was asked to explain the process for medication reconciliation and medication interaction review, for patients admitted to the agency. She stated during the SOC assessment visit the clinician completed the medication list. After the SOC visit, the completed medication list	{G 337}	(continued from page 1) duplicative drug therapy, and noncompliance with drug therapy. The drug regimen review/flow process utilized by the agency as well as the agency Medication Policies and Procedures 9.3, 9.3.1, 9.4 and 9.8 have been reviewed and revised with involvement and input of the clerical and clinical staff. An in-service focusing on the process and policy revisions was conducted on 3/11/15. The agency has adopted the Home Health Quality Improvement Best Practice Intervention Package – Medication Management as a guide for process improvement. Touchmark consultants will assist in monitoring drug regime review compliance through monthly focused chart audits. Ongoing monitoring will be conducted by the clinical supervisor. Please see also attachments 1 through 10.	

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{G 337}	Continued From page 2	{G 337}		

was turned into the office. The Clinical Director stated either she entered the medications into the computer software program or an office staff member would, because they were the only staff with software access. The Clinical Director stated a medication list was created by the program, along with a medication interaction report. She stated both the medication list and interaction report were printed and reviewed by her initially, and then given to the clinician, who performed the SOC assessment, for review. The clinicians review the forms, then sign and date the medication list. The Clinical Director stated an office staff faxes the medication list and interaction report to the attending physician for review.

Medication reviews were not completed consistent with the above policies and described processes. Examples include:

1. Patient #7 was a 91 year old female admitted to the agency on 2/26/15 for SN, PT, OT, and HHA services. Diagnoses included bilateral lower extremity edema, chronic pain, CKD Stage II, chronic abdominal pain, nausea, and DM Type II. Patient #7's record including the POC, for the certification period 2/26/15 to 4/26/15, was reviewed.

Patient #7's SOC assessment, dated 2/26/15, was completed and signed by the RN Case Manager. On the SOC assessment, the RN Case Manager checked a box to indicate "Problems found during [the medication] review." Another box was checked by the RN Case Manager to document the physician was notified of the problems found during the medication review within 1 calendar day.

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{G 337}	Continued From page 3	{G 337}		

However, in the narrative notes section of the SOC assessment, the RN Case Manager documented she was unable to review all of Patient #7's medications during the visit, and she would review them at the next SN visit. The problems found during the review were not documented.

The medication list and medication interactions report, dated 2/26/15, signed by the Clinical Director, had a stamp imprinted on it which indicated it was faxed to Patient #7's attending physician on 2/26/15. The medication information was sent to the physician although a thorough medication review was not completed.

During an interview on 3/04/15 at 12:15, Patient #7's RN Case Manager, who completed the SOC assessment on 2/26/15, reviewed the record and confirmed she was unable to review all of Patient #7's medications during the SOC visit. She stated the narrative note, documented on the SOC assessment, was written on 2/27/15, the day after the SOC visit but she was unable to remember at what time.

A complete medication review and reconciliation was not performed for Patient #7 at the time of her 2/26/15 SOC assessment.

2. Patient #3 was a 66 year old male admitted to the agency on 11/01/14, for care related to a decubitus ulcer. Additional diagnoses included cerebral palsy and depression. He received SN services. His record, including the POC, for the certification period 12/31/14 to 2/28/15, was reviewed.

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{G 337}	Continued From page 4	{G 337}		

The RN Case Manager completed the Recertification assessment, dated 12/26/14. On the Recertification assessment, the RN Case Manager checked a box to indicate "Problems found during [medication] review." Additionally, another box was checked to document the physician was notified of the problems found during the medication review within 1 calendar day. The documentation did not include clarification of the problems identified with the medications, or document whether changes were made to Patient #3's prescribed medications.

Patient #3's record included a form titled "Medication Interactions." The form included the medications on the POC for the certification period 12/31/14 to 2/28/15. Additionally, the 5-page form included interactions between his medications, with the classification of review suggested, potential interaction risk, or intervention required. The RN Case Manager signed the form on 2/02/15. The form-listed intervention required with the following medication combinations:

-Lisinopril 40 mg oral tablet with Potassium Chloride 10 meq 4 oral tablets daily. The severity was classified as "Major," indicated the combination may result in increased potassium levels in the blood.

-Promethazine 25 mg oral tablet every 6 hours as needed with Tramadol 50 mg 2 oral tablets twice a day or four times a day as needed. The severity was classified as "Major," and indicated the combination may result in an increased risk of seizures.

-Sertraline 50 mg oral tablet with Tramadol 50 mg

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{G 337}	Continued From page 5 2 oral tablets twice a day or four times a day as needed. The severity was classified as "Major," stating the combination may result in an increased risk of seizures and serotonin syndrome (hypertension, myoclonus, and mental status changes). -Duloxetine Hydrochloride 30 mg oral capsule with Tramadol 50 mg 2 oral tablets twice a day or four times a day as needed. The severity was classified as "Major," stating the combination may result in an increased risk of serotonin syndrome. -Sertraline 50 mg oral tablet every 6 hours as needed with Duloxetine Hydrochloride 30 mg oral capsule. The severity was classified as "Major," stating the combination may result in an increased risk of serotonin syndrome. -Promethazine 25 mg oral tablet every 6 hours as needed with Quetiapine Fumarate 50 mg oral tablet. The severity was classified as "Major," stating the combination may result in an increased risk of QT interval prolongation (a measure of time between the start and end of the heart's electrical cycle). During an interview on 3/03/15 beginning at 2:40 PM, the Clinical Director confirmed there was no stamp, to indicate the medication list and interactions report were faxed to the attending physician. Patient #3's physician was not alerted to medication interactions. 3. Patient #1 was a 94 year old female admitted to the agency on 10/16/14 for PT services. Diagnoses included care involving physical	{G 337}		

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{G 337}	Continued From page 6	{G 337}		

therapy, muscle weakness, abnormal gait, joint pain, depression, and history of fall. Patient #1's medical record, including the POC, for the certification period 2/14/15 to 4/14/15, was reviewed.

The Recertification assessment, dated 2/12/14, was completed by the Physical Therapist. On the Recertification assessment a box was checked, indicating "Problems found during [medication] review." However, another box was checked by the Physical Therapist to document the physician was not notified of the problems. The documentation did not include clarification of the problems identified with the medications, or document whether changes were made to Patient #1's prescribed medications.

Additionally, Patient #1's record included a medication list and medication interactions report, dated 2/13/15. The medication interactions report documented 2 "Major" drug interactions and 4 moderate interactions.

- A severity level of "Major" was identified between Trazodone and Citalopram. The warning stated that taking these medications concurrently may result in a life-threatening condition called Serotonin syndrome.

The National Institutes of Health website, accessed 3/05/15, 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

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{G 337}	Continued From page 7	{G 337}		

if untreated, is deadly.

- A severity level of "Major" was identified between Aspirin and Citalopram. When used concurrently, they may increase the risk of bleeding.

During an interview on 3/03/15 at 2:40 PM, the Clinical Director reviewed the record and confirmed the Physical Therapist had documented problems were found and Patient #1's physician was not notified. She further confirmed there was no stamp which indicated the medication list and interactions report were faxed to the attending physician.

Patient #1's physician was not alerted regarding drug interactions found during the medication review.

4. Patient #2 was a 92 year old male admitted to the agency on 10/20/14, for care related to uncontrolled diabetes. Additional diagnoses included bone disease, foot ulcer, congestive heart failure, and atrial fibrillation. He received SN services. His record, including the POC, for the certification period 2/17/15 to 4/17/15, was reviewed.

The RN Case Manager completed the Recertification assessment, dated 2/16/15. On the Recertification assessment, the RN Case Manager checked a box to indicate "Problems found during [the medication] review." Additionally, the RN Case Manager checked another box to document the physician was notified of the problems found during the medication review within 1 calendar day. The documentation did not include clarification of the

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{G 337}	Continued From page 8	{G 337}		

problems identified with the medications, or document whether changes were made to Patient #2's prescribed medications.

Patient #2's record included a form titled "Medication Interactions." The form included the medications on the POC for the certification period 2/17/15 to 4/17/15. Additionally, the 6-page form included interactions between his medications, with the classification of review suggested, potential interaction risk, or intervention required. The form did not include a signature or date. The form-listed intervention required with the following medication combinations:

-Calcium 600 and Vitamin D oral 1 tablet with Digoxin oral 0.125 mg tablet. The severity was classified as "Major," stating the combination may result in a serious risk of arrhythmia and cardiovascular collapse.

-Metoprolol 25 mg oral tablet with Proair inhale 2 puffs every 4 hours as needed. The severity was classified as "Major" warning, stating the combination may result in decreased effectiveness of either medication and may also result in narrowing of the airway into the lungs.

During an interview on 3/03/15 beginning at 2:40 PM, the Clinical Director confirmed there was no stamp, to indicate the medication list and interactions report were faxed to the attending physician.

Patient #2's physician was not alerted to medication interactions.

5. Patient #5 was a 92 year old female admitted

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{G 337}	Continued From page 9	{G 337}		

to the agency on 4/22/11, for care related to B-complex deficiencies. Additional diagnoses included angiodysplasia of the intestines, and anemia. She received SN services. Her record, including the POC, for the certification period 1/31/15 to 3/31/15, was reviewed.

The RN Case Manager completed the Recertification assessment, dated 1/30/15. On the Recertification assessment a box was checked, indicating "Problems found during (medication) review." Additionally, the RN Case Manager checked another box to document the physician was notified of the problems found during the medication review within 1 calendar day. The documentation did not include clarification of the problems identified with the medications, or document whether changes were made to Patient #5's prescribed medications.

Patient #5's record included a form titled "Medication Interactions." The form included the medications on the POC for the certification period 1/31/15 to 3/31/15. Additionally, the 1-page form included interactions between her medications, with the classification of review suggested, potential interaction risk, or intervention required. The RN Case Manager signed the form on 2/06/15. The form-listed intervention required with the following medication combinations:

-Fentanyl 25 mcg transdermal patch with Oxycodone Hydrochloride 5 mg tablet one half to one every 4 hours as needed. The severity was classified as "Major," indicating the combination may result in additive respiratory depression.

During an interview on 3/03/15 beginning at 2:40

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{G 337}	Continued From page 10 PM, the Clinical Director confirmed there was no stamp, which indicated the medication list and interactions report were faxed to the attending physician. Patient #5's physician was not alerted to medication interactions.	{G 337}		

Bureau of Facility Standards

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{N 000}	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the follow up survey of your home health agency completed 3/03/15 through 3/04/15. Surveyors conducting the review were: Don Sylvester, RN, HFS, Team Lead Laura Thompson, RN, HFS Acronyms used in this report include: CKD - Chronic Kidney Disease DM - Diabetes Mellitus HHA - Home Health Aide mcg - micrograms meq - milliEquivalent mg - milligrams OT - Occupational Therapist POC - Plan of Care PT - Physical Therapist PRN - as needed QT interval prolongation - a measure of time between the start and end of the hearts electrical cycle RN - Registered Nurse SOC - Start of Care SN - Skilled Nurse	{N 000}	RECEIVED MAR 2 5 2015 FACILITY STANDARDS	
{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	{N 173}	Please see response for corresponding G337 tag	

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

Bureau of Facility Standards

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(N 173)	Continued From page 1 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)		