IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

October 31, 2017

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

RE: Touchmark Home Health, Provider #137092

Dear Mr. Hoskin:

Based on the survey completed at Touchmark Home Health, on October 23, 2017, by our staff, we have determined the agency is out of compliance with the Medicare Home Health Agency (HHA) Condition of Participation of **Home Health Aide Services (42 CFR 484.36)**

To participate as a provider of services in the Medicare Program, an HHA must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

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

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

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- 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 **November 10, 2017**. It is suggested that the Credible Allegation of Compliance/Plan of Correction for each Condition of Participation and related standard level deficiencies show compliance no later than **December 7, 2017,** 45 days from survey exit. 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:

- Civil Monetary Penalty (42 CFR 488.820(a))

- Termination (42 CFR 488.865)

We must recommend to the CMS Regional Office and /or State Medicaid Agency that your provider agreement be terminated (42 CFR 488.865) on **April 21, 2018**, if substantial compliance is not achieved by that time.

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 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 IDR Guidelines. The IDR Guidelines can be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NonLongTermCare/tabid/427/Default.aspx

Scroll down to Home Health Agencies (HHA) and select the following:

Informal Dispute Resolution (IDR)

IDR Guidelines

IDR Request Form

This request must be received by **November 10, 2017.** If your request for IDR is received after **November 10, 2017 ,** 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).

We urge you to begin correction immediately.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

Dennis Kelly RN

DENNIS KELLY, RN, Supervisor
Non-Long Term Care

DK/pmt
Enclosures

ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Patrick Thrift, Survey & Certification Manager Region X
Julius Bunch, Certification & Enforcement Manager Region X

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 agency conducted on 10/16/17 to 10/23/17. Surveyors conducting the recertification survey were: Nancy Bax, RN, BSN, HFS, Team Lead Teresa Hamblin, RN, MS, HFS Acronyms used in this report include: ABD - Abdominal Pad BLE - Bilateral Lower Extremities CHF - Congestive Heart Failure CKD - Chronic Kidney Disease CVA - Cerebral Vascular Accident (stroke) DM - Diabetes Mellitus INR - International Normalized Ratio HHA - Home Health Agency HTN - Hypertension IV - Intravenous LLE - Lower Left Extremity MAHC - Missouri Alliance for Home Care MSW - Medical Social Worker MT - Mountain Time OT - Occupational Therapist OTC - Over-the-counter PA - Physician's Assistant POC - Plan of Care PRN - as needed PT - Physical Therapy Pt - Patient PTA - Physical Therapy Assistant RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care	G 000	RECEIVED NOV 06 2017 FACILITY STANDARDS	
G 134	484.14(c) ADMINISTRATOR	G 134		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matthew Hoskins	Administrator	11/3/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE 8 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 134	Continued From page 1 The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations. This STANDARD is not met as evidenced by: Based on staff interview and review of personnel files it was determined the agency's Administrator failed to ensure personnel were qualified as evidenced by lack of documentation of annual evaluations for 7 of 8 clinicians (Staff A to G) who were employed by the agency for more than 1 year and whose personnel records were reviewed. This failure had the potential for care to be provided by unqualified personnel. The findings include: Personnel files of Staff A to G were provided and reviewed on 10/19/17. Staff A was an RN hired on 4/11/11. Her file did not include a performance evaluation. Staff B was an RN hired on 10/07/15. Her file did not include a performance evaluation. Staff C was an RN hired on 12/01/15. Her file did not include a performance evaluation. Staff D was an RN hired on 7/28/16. Her file did not include a performance evaluation. Staff E was an MSW hired on 9/23/15. Her file did not include a performance evaluation. Staff F was an OT hired on 5/01/13. His file did not include a performance evaluation.	G 134	G 134 - 484.14(c) 1. Director or Clinical Manager will complete an annual evaluation form for each employed clinician between January 1st and December 31st of each calendar year. The evaluation form will include review of participation in required Home Health education modules, compliance with licensure and certification requirements, and observation/review of one home visit. Documentation of the annual evaluation will be submitted to the Administrator for review. Once completed the evaluation will be kept in the employee's human resource file. 2. This will improve the processes by having a singular evaluation form for all clinicians and will keep records of this action in one location for review. 3. The Administrator, Director and Clinical Manager will be educated by November 20th 2017. 4. To meet standards, past due clinician evaluations will be completed by December 7th 2017. 5. An outlook calendar reminder will be utilized by the Director and HR Manager. 6. Implementation by Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER C>R SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 134	Continued From page 2 Staff G was a PT hired on 11/30/15. His file did not include a performance evaluation. During an interview on 10/19/17 at 12:10 PM, tha Clinical Services Manager stated the organization stopped doing employee evaluations a couple of years ago. She confirmed there was no documentation of employee performance evaluations for Staff A to G. On 10/19/17 at 4:25 PM, the Clinical Services Manager provided an email sent to her by the organization's Home Health Specialist on 10/19/17 at 4:06 PM MT. The email stated "Touchmark does not do formal annual evaluations like they did several years ago." The agency's Administrator failed to ensure routine clinician evaluations were completed.	G 134	G 144 484.14(g) 1. For patient's identified to have transmittable infections, or orders for blood, urine, nasal, fecal, throat or sputum cultures, the patient's case manager will notify in writing via a communication note that is dated, timed, and signed, to the Clinical Manager, or Infection Control RN, who will track for results in the Infection Control Tracking Log. When positive results are identified, the Clinical Manager, or Infection Control RN, will notify via a communication note that is dated, timed, and signed, to all clinicians who are in contact with that patient, including the results and the precautions that must be followed. 2. This action will improve infection tracking and notification to at risk clinicians. 3. All clinical staff will be educated on the infection control process by November 20th 2017. 4. Completion date by December 7th 2017. 5. Infection Control Log will be audited quarterly by Director or Clinical Manager for compliance. 6. Implementation by Clinical Manager.	
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 medical record review, policy review, and staff interview, it was determined the agency failed to ensure efforts to coordinate care were documented for 1 of 10 patients (Patient #6) who received care from more than 1 skilled discipline and whose records were reviewed. This failure had the potential to interfere with quality of patient care. Findings include:	G 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEACTH	625 SOUTH ARBOR LANE, SUITE B 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 144	Continued From page 3	G 144		

The agency's policy "PROGRESS NOTES CARE COORDINATION," undated, stated "It is the responsibility of the practitioner writing the note to report the contents to the other members of the interdisciplinary team that need to know its contents."

Patient #6 was an 87 year old female admitted to the agency on 10/02/17, with a primary diagnosis of stage 2 pressure ulcers to her feet. Additional diagnoses included venous insufficiency, chronic ulcers to her legs, and obesity. She received SN, PT, OT, MSW, and aide services. Her record, including the POC, for the certification period 10/02/17 to 11/30/17, was reviewed.

Patient #6's record included an SN visit note dated 10/06/17, signed by the RN Case Manager. The note stated cultures of her wounds were completed and Staphylococcus aureus (staph) was identified in all of her wounds.

The Mayo Clinic website, accessed 10/20/17, included information on staph infections. It stated "These bacteria can also be transmitted from person to person. Because staph bacteria are so hardy, they can live on inanimate objects such as pillowcases or towels long enough to transfer to the next person who touches them."

Patient #6's record did not include documentation stating the other clinicians involved in her care were notified of her staph infections. This was important to ensure proper infection control procedures were used to prevent transmission of the bacteria to the clinicians, or to other patients receiving care from the agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 144	Continued From page 4 During an interview on 10/19/17 at 9:55 AM, the Clinical Services Manager reviewed Patient #6's record and confirmed it did not include documentation of communication related to her staph infections. She stated Patient #6's status was discussed during a case conference, but it was not documented. The agency failed to ensure Patient #6's record included documentation of communication to clinicians related to her staph infection.	G 144	G 146 484.14(h) 1. All contracts will be reviewed by the Director to include the following standards: a. Patients are accepted for care only by the primary HHA. b. Contracting agencies will participate in the development of plans of care as it pertains to the contracted discipline. c. Specify the manner in which services would be controlled, coordinated, and evaluated by the primary HHA. d. Specify the procedures for submitting clinical and progress notes, scheduling of visits, and periodic patient evaluation. 2. This action will lead to contract compliance per 484.14(h) requirements. 3. The Director will review all current contracts. 4. Completion date by December 7th, 2017. 5. All new contracts will be reviewed prior to signature by the Director. 6. Implementation by Director.	
G 146	484.14(h) SERVICES UNDER ARRANGEMENTS Services furnished under arrangements are subject to a written contract conforming with the requirements specified in paragraph (f) of this section and with the requirements of section 1861(w) of the Act (42 U.S.C 1495x(w)). This STANDARD is not met as evidenced by: Based on review of contracts and staff interview, it was determined the agency failed to ensure written contracts met all requirements specified at CFR 484.14(f) for 1 of 3 contracts (Contract C) that were reviewed. This resulted in an incomplete contract. It had the potential to interfere with clarity of expectations and coordination of patient care. Findings include: Contract C was reviewed. It did not include information required at CFR 484.14(f). Examples include: - It did not specify that patients were accepted for care only by the primary HHA.	G 146		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 146	Continued From page 5 - It did not specify responsibility for participating in development of plans of care. - It did not specify the manner in which services would be controlled, coordinated, and evaluated by the primary HHA. - It did not specify the procedures for submitting clinical and progress notes, scheduling of visits, and periodic patient evaluation. The Biller/Coder was interviewed on 10/19/17 at 4:30 PM. She reviewed Contract C and confirmed information was missing. The written contract did not conform to requirements at CFR 484.14(f).	G 146	G158 484.18 1. A. All verbal orders will be annotated by the clinician with the name of the ordering physician and the clinical representative physician authorizes to relay the verbal order, the date, the time and the receiving clinicians name and credentials. B. All correctly documented verbal orders, naming the ordering physician, may be implemented before signature is received. 1. Verbal orders from a PA or NP will not be implemented. C. All written orders will not be implemented without a physician signature. D. If a verbal or written order is received from a Non-Physician Practioner, it will be submitted to the following physician for signature before it is implemented. - Continued next page	
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on review of medical records, policy review, observation, and staff interview, it was determined the agency failed to ensure patients' care was ordered by a physician and care followed a physician's written POC for 3 of 12 patients (#6, #7, and #10) whose records were reviewed. This failure had the potential to result in omissions of care and unmet patient needs. Findings include: The agency's policy "MEDICAL POLICIES AND PHYSICIAN'S ORDERS," reviewed and revised	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 158	Continued From page 6 9/12/17, stated "All clients who receive skilled home health services will have orders for all services from a physician." Additionally, it stated "Treatment ordered by the physician shall be the only medical treatments carried out." 1. Patient #7 was a 78 year old female admitted to the agency on 9/22/17, for care following a total knee replacement. Additional diagnoses included encephalitis, pulmonary emboli, and HTN. She received SN, PT, and aide services. Her record, including the POC, for the certification period 9/22/17 to 11/20/17, was reviewed. a. Patient #7's record included a "Home Health Continuation Note," dated 9/22/17, signed by the admitting RN. The note stated the RN called a PA during Patient #7's SOC assessment and received a verbal order for continuation of home health services, medications, and an INR blood test to be completed on 9/23/17. The orders were documented on Patient #7's POC, and signed by her physician on 10/05/17. Orders for home health services were not obtained from a physician prior to 10/05/17. b. Patient #7's record included a "Physician Interim Orders" form, dated 9/22/17. The form stated a verbal order was obtained from a PA, for a change in Patient #7's Coumadin dosage and INR blood test to be obtained on 9/23/17. The order was signed by a physician on 9/25/17, after the Coumadin dosage was adjusted and the blood test completed. c. A visit was made to Patient #7's home on 9/18/17 at 11:00 AM, to observe an SN visit. During the visit, the RN completed an INR test. She called the results to a PA and received an	G 158	G158 - 484.18 continued: E. All services ordered at start of care will be monitored by the care coordinator and/or the clinical manager to ensure timely evaluation is performed within the first 6 days of service. 1. If specific service cannot be provided, the referral will be declined. 2. If the patient delays service, the physician will be notified by the scheduling clinician and it will be documented in a communication note. F. All medications will be ordered by the physician and documented in the medical record. G. Recommendations will not be made without a physician's order. 2. This action will guide clinicians on acceptable verbal and written orders, and medication management. 3. All clinicians will be educated by November 20th 2017. 4. Completion date December 7th 2017. 5. The Director or Clinical Manager will audit 10% of charts quarterly for continued compliance. 6. Implementation by Clinical Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 158	Continued From page 7 order to decrease Patient #7's Coumadin dosage, and repeat the INR in 3 days. The RN adjusted the Coumadin in Patient #7's medication box, based on the order taken from the PA During an interview on 10/19/17 at 10:10 AM, the RN Case Manager confirmed orders for home health services, medications, and blood tests were obtained from a PA who acts as Patient #7's primary care provider. She stated the orders were sent to a physician for signature, but care was provided prior to physician approval of the orders. The agency failed to ensure Patient #7's care was ordered by a doctor of medicine, osteopathy, or podiatric medicine. 2. Patient #6 was an 87 year old female admitted to the agency on 10/02/17, with a primary diagnosis of stage 2 pressure ulcers to her feet. Additional diagnoses included venous insufficiency, chronic ulcers to her legs, and obesity. She received SN, PT, OT, MSW, and aide services. Her record, including the POC, for the certification period 10/02/17 to 11/30/17, was reviewed. a. Patient #6's record included an order for wound care dated 9/29/17. The order was signed by a PA The order did not include a physician's signature. During an interview on 10/19/17 at 9:55 AM, the Clinical Services Manager reviewed the wound care order and confirmed it was signed by a PA She stated the order was from a wound care clinic and was not authorized by a physician.	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 158	Continued From page 8 The agency failed to ensure Patient #6's wound care was ordered by a doctor of medicine, osteopathy, or podiatric medicine. b. Patient #6's POC, effective 10/02/17, included an order for OT visits 1 time a week for 4 weeks. Her record did not include an OT visit note for the week of 10/02/17 to 10/07/17. An OT evaluation was documented on 10/10/17, 8 days after her SOC. There was no documentation of the reason for the delay in implementation of OT services. During an interview on 10/19/17 at 9:55 AM, the Clinical Services Manager reviewed Patient #6's POC and confirmed it included an order for an OT visit during week 1 of her certification period. She stated an OT visit was not provided as ordered. Patient #6 did not receive an OT visit during week 1 of her certification period, as ordered on her POC. 3. Patient #10 was a 64 year old male admitted to the agency on 1/30/17, with a primary diagnosis of varicose veins of LLE with ulcer of other part of lower extremity. Additional diagnoses included wounds on the right lesser toes, lymphedema, polyneuropathy, obesity, Parkinson's disease, and major depressive disorder. He received SN, PT, and aide services. His record, including the POC, for certification period 3/31/17 to 5/29/17, was reviewed. Patient #10's POC was not followed. Examples include: a. The POC, dated 3/31/17, included wound care orders, as follows:	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 158	Continued From page 9 - Location: LLE and right 5th toe plantar - Normal Saline, barrier to surrounding area, oil emulsion dressing, diaper Kerlix - Frequency: 2-3 times a week and as needed An RN note, "Transfer to Inpatient Facility," dated 4/06/17, documented Patient #10 was admitted to the hospital on 4/05/17, related to wound complications. An RN visit note, "Resumption of Care," dated 4/08/17, documented Patient #10 was discharged with a diagnosis of cellulitis and without specific wound orders. An RN visit note, dated 4/11/17, documented providing wound care and dressing change to Patient #1O's right 5th toe and LLE. There were no wound orders present at the time the wound care was provided on 4/11/17. Wound care orders, dated 4/14/17, were received 3 days after wound care was provided. The Home Health Director was interviewed on 10/19/17 beginning 9:00 AM. He reviewed Patient #1O's record and stated wound care orders should have been obtained prior to providing wound care on 4/11/17. He confirmed wound care orders were not present on 4/11/17. Wound care was provided to Patient #1O without specific orders. b. An RN visit note, dated 4/18/17, was reviewed. It stated the RN instructed Patient #10 that Zyrtec OTC may help with allergy symptoms. Zyrtec was not included on the POC for the	G 158		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 158	Continued From page 10 certification period 3/31/17 to 5/29/17. The Home Health Director was interviewed on 10/19/17 beginning 9:00 AM. He reviewed Patient #1O's record and confirmed the POC did not include Zyrtec. SN recommended a medication that was not included in Patient #1O's POC. c. An RN "Continuation Note," dated 4/18/17, stated the RN applied Lidocaine jelly to the wound on Patient #1O's 5th toe/plantar surface. The most recent wound care orders, dated 4/14/17, did not include application of Lidocaine. The Home Health Director was interviewed on 10/19/17 beginning 9:00 AM. He reviewed Patient #1O's record and confirmed he could not find orders for the Lidocaine. Wound care provided to Patient #10 was not consistent with a physician approved POC.	G 158	G159 - 484.18(a) 1. A. Wound care orders will be reviewed for completeness by the Clinical Manager and the Case Manager. B. Incoming and outgoing wound care orders will be placed in the Clinical Managers basket. Once reviewed and initialed, the orders will be put in the receptionist basket for records scanning or outgoing fax. C. Complete wound care orders, including DME, will be obtained before performing the visit. D. Oxygen will be included on the medication list. E. Oxygen DME will be indicated on patient DME list. 2. A. This increased review by the Clinical Manager will help catch incomplete wound care orders before reaching the field clinician. B. Including Oxygen on the medication list and Oxygen supplies on the DME will meet regulatory requirements. 3. Education to all staff by November 20th 2017. 4. Completion date December 7th 2017. 5. 10% chart audits quarterly for continued compliance. 6. Implementation by Clinical Manager.	
G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.	G 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE 8 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 159	Continued From page 11 This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the agency failed to ensure POCs included all interventions, equipment, and medications for 2 of 11 patients (#6 and #10) whose records were reviewed. This failure had the potential to result in unmet patient needs and adverse patient outcomes. Findings include: 1. Patient #6 was an 87 year old female admitted to the agency on 10/02/17, with a primary diagnosis of stage 2 pressure ulcers to her feet. Additional diagnoses included venous insufficiency, chronic ulcers to her legs, and obesity. She received SN, PT, OT, MSW, and aide services. Her record, including the POC, for the certification period 10/02/17 to 11/30/17, was reviewed. Patient #6's record included referral orders from a wound care clinic. The orders included wound care as follows: - "Remove existing dressing, cleanse with wound cleanser - Pat with sterile gauze - Apply medihoney to wound bed of right foot and bilateral legs - Cover left heel with absorbent pad (please obtain heel cup if possible to place over heel) - Cover legs with triact and ABD - Secure with roll gauze and tubigrips - Change dressing three times weekly as	G 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING ____ B. WING ____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 159	Continued From page 12 indicated above and PRN if saturated or lifting, or as needed to assess wound site - Please cover right lover hip with Mepilex border Compression: Double layer tubigrips to BLE (size E) Offloading: EHOB boot to left heel (heel offloading boot)" Patient #6's POC included an order for wound care to her lower extremities to be completed 3 times a week . The order stated "medihoney plus triac plus cover." Her POC did not include an order to cleanse her wounds, to secure the dressings with gauze and tubi grips, or to cover her right lover hip with Mepilex border. Her POC did not include a heel offloading boot. During an interview on 10/19/17 at 9:55 AM, the Clinical Services Manager reviewed Patient #6's POC and confirmed it did not include her boot or complete wound care orders. The agency failed to ensure Patient #6's POC included all orders and equipment used for her care. 2. Patient #10 was a 64 year old male admitted to the agency on 1/30/17, with a primary diagnosis of varicose veins of LLE with ulcer of other part of lower extremity. Additional diagnoses included wounds on the right lesser toes, lymphedema, polyneuropathy, obesity, Parkinson's disease, and major depressive disorder. He received SN, PT, and aide services. His record, including the POC, for certification period 3/31/17 to 5/29/17, was reviewed. The recertification SN assessment, dated	G 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 159	Continued From page 13 3/29/17, indicated Patient #10 used oxygen at 2 liters per minute at night via nasal cannula. The POC for the certification period 3/31/17 to 5/29/17, did not include oxygen orders. The Home Health Director was interviewed on 10/19/17 beginning 9:00 AM. He reviewed Patient #1O's record and stated oxygen should have been included on the medication list on the POC. Patient #1O's POC did not include oxygen use.	G 159	G166 484.18 1. A. All verbal orders will be annotated by the clinician with the name of the ordering physician and the clinical representative physician authorizes to relay the verbal order, the date, the time and the receiving clinicians name and credentials. B. All correctly documented verbal orders, naming the ordering physician, may be implemented before signature is received. 1. Verbal orders directly from a PA or NP will not be implemented. C. All written orders must have a physician signature to be implemented. D. If a verbal or written order is received from a Non-Physician Practitioner, it will be submitted to the following physician for signature before it is implemented.	
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on medical record review, policy review, and staff interview, it was determined the agency failed to ensure verbal orders were put in writing for 2 of 12 patients (#7 and #10) whose records were reviewed. This had the potential to negatively impact coordination and clarity of patient care. Findings include: The agency's policy "MEDICAL POLICIES AND PHYSICIAN'S ORDERS," reviewed and revised 9/12/17, stated "Verbal orders are put in writing and signed and dated with the date of receipt by the RN or qualified therapist responsible for furnishing or supervising the ordered services."	G 166	Continued next page	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 166	Continued From page 14 1. Patient #10 was a 64 year old male admitted to the agency on 1/30/17, with a primary diagnosis of varicose veins of LLE with ulcer of other part of lower extremity. Additional diagnoses included wounds on the right lesser toes, lymphedema, polyneuropathy, obesity, and Parkinson's disease, and major depressive disorder. He received SN, PT, and aide services. His record, including the POC, for certification period 3/31/17 to 5/29/17, was reviewed. An RN note, "Care Coordination," dated 4/14/17, documented Patient #1O's physician "asked that we go out tomorrow and start a peripheral IV to do direct IV push of antibiotics." An RN note, "Care Coordination," dated 4/15/17, documented an RN made several unsuccessful attempts to establish a peripheral IV. The verbal communication from the physician to start the peripheral IV and push the antibiotics was not put in writing and countersigned by the physician. The Home Health Director was interviewed on 10/19/17 beginning 9:00 AM. He reviewed Patient #1O's record and stated he did not find a written order for the verbal order received. A verbal order received for Patient #1O was not put in writing and countersigned by the physician. 2. Patient #7 was a 78 year old female admitted to the agency on 9/22/17, for care following a total knee replacement. Additional diagnoses included encephalitis, pulmonary emboli, and HTN. She received SN, PT, and aide services. Her record,	G 166	G166 – Continued. 484.18 E. All services ordered at start of care will be monitored by the care coordinator and/or the clinical manager to ensure timely evaluation is performed within the first 6 days of service. 1. If specific service cannot be provided, the referral will be declined. 2. If the patient delays service, the physician will be notified by the scheduling clinician and it will be documented in a communication note. F. All medications will be ordered by the physician and documented in the medical record. G. Recommendations will not be made without a physician's order. 2. This action will guide clinicians on acceptable verbal and written orders, and medication management. 3. All clinicians will be educated by November 20th 2017. 4. Completion date December 7th 2017. 5. The Director or Clinical Manager will audit 10% of charts quarterly for continued compliance. 6. Implementation by Clinical Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE 8 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)	(XS) COMPLETION DATE
G 166	Continued From page 15 including the POC, for the certification period 9/22/17 to 11/20/17, was reviewed. a. Patient #7's record included an SN visit note dated 9/23/17, signed by the RN Case Manager. The note stated an INR blood test was completed and a verbal order was obtained to increase Patient #7's dose of Coumadin and repeat the INR on 9/24/17. Patient #7's record did not include a written physician's order dated 9/23/17, for a change in her Coumadin dosage, and repeat INR. b. Patient #7's record included an SN visit note dated 9/24/17, signed by the RN Case Manager. The note stated an INR blood test was completed and a verbal order was obtained to increase Patient #7's dose of Coumadin and repeat the INR on 9/25/17. Patient #7's record included an order dated 9/24/17, to repeat her INR on 9/25/17. However, the order did not include the change in her Coumadin dosage. During an interview on 10/19/17 at 10:10 AM, the RN Case Manager reviewed Patient #7's record and confirmed she received an order on 9/23/17. She stated she failed to complete a written order to be sent to the physician for signature. She stated she did complete a written order on 9/24/17, to repeat the INR, but she did not include the increased Coumadin dosage. Patient #7's RN Case Manager failed to put verbal orders in writing.	G173 G 166	484.30(a) 1. A. The medication profile maintained in the client clinical record will be updated ongoing. B. All medication changes will be documented on the medication profile by the clinician, as well as the skilled clinician visit. 2. Reduced medication documentation errors by having the identifying clinician enter their own medications into the computer system. 3. All Clinicians will be educated by November 20th 2017. 4. Completion date December 7th 2017. 5. 10% of all charts will be audited quarterly for continued compliance. 6. Implementation by Clinical Manager.	
G 173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and	G 173		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 173	Continued From page 16 necessary revisions. This STANDARD is not met as evidenced by: Based on medical record review, policy review, and staff interview, it was determined the agency failed to ensure the RN updated the POC to reflect medication changes for 1 of 12 patients (Patient #10) who received SN services, and whose records were reviewed. This failure had the potential to result in unidentified incompatibilities among medications and to disrupt coordination of patient care. Findings include: An undated policy, "MEDICATION MANAGEMENT AND ADMINISTRATION," was reviewed. It included the following statements: - "The medication profile maintained in the client clinical record will be updated ongoing..." - "All medication changes will be documented on the medication profile as well as the skilled clinician visit" This policy was not followed. An example includes: Patient #10 was a 64 year old male admitted to the agency on 1/30/17, with a primary diagnosis of varicose veins of LLE with ulcer of other part of lower extremity. Additional diagnoses included wounds on the right lesser toes, lymphedema, polyneuropathy, obesity, Parkinson's disease, and major depressive disorder. He received SN, PT, and aide services. His record, including the POC, for certification period 3/31/17 to 5/29/17, was reviewed.	G 173		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 173	Continued From page 17 An RN visit note, dated 4/26/17, was reviewed. It stated Patient #10 completed his Augmentin on 4/26/17. The POC was not updated to reflect that Patient #10 began or completed a course of Augmentin. The Home Health Director was interviewed on 10/19/17 beginning 9:00 AM. He reviewed Patient #10's record and confirmed the POC did not include the medication Augmentin. The RN did not update Patient #10's POC to include the order for Augmentin.	G 173	G176 484.30(a) 1. The clinician who discovers changes in a patient's condition will notify the physician of the changes at the time of incident. If the discovering clinician is not the case manager, they will also notify the assigned case manager. Both notifications will be documented on the visit note or on a communication note. 2. This action will ensure the physician is notified by the clinician with eyes on the patient. The physician will have opportunity to ask questions and give instruction. 3. Staff will be educated by November 20th 2017. 4. Completion by December 7th 2017. 5. 100% of hospital transferred charts will be audited for compliance for 90 days beginning 11/1/2017. 10% of all charts will be audited quarterly for continued compliance. 6. Implementation by the Clinical Manager.	
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on medical record review, policy review, and staff interview, it was determined the agency failed to ensure RN staff informed the physician of significant changes in patient condition for 1 of 12 patients (Patient #10) who received SN services, and whose records were reviewed. This failure had the potential to result in a missed opportunity for prompt physician intervention to update the plan of care. It also had the potential for adverse patient outcomes. Findings include: The policy "MEDICAL POLICIES AND PHYSICIAN'S ORDERS," dated 9/12/17, was	G 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEACTH	625 SOUTH ARBOR LANE, SUITE B 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 176	Continued From page 18 reviewed. The policy included the following information: - The nurse or therapist notifies the physician each time there is a significant change in client's status for which professional judgment determines the need for physician involvement. - The physician is notified each time the client's condition changes... This policy was not followed. An example includes: Patient #10 was a 64 year old male admitted to the agency on 1/30/17, with a primary diagnosis of varicose veins of LLE with ulcer of other part of lower extremity. Additional diagnoses included wounds on the right lesser toes, lymphedema, polyneuropathy, obesity, Parkinson's disease, and major depressive disorder. He received SN, PT, and aide services. His record, including the POC, for certification period 3/31/17 to 5/29/17, was reviewed. He was hospitalized 4/06/17 to 4/07/17 for cellulitis. An RN note, "Care Coordination," dated 5/12/17, was reviewed. It stated the PTA had called the RN to report Patient #10 had a temperature of 99.6 degrees, felt like he had cellulitis and changes in his cognition. It also stated Patient #10 explained he had a "hotspot on his upper leg in the folds of skin." The RN documented advising Patient #10 to go to an urgent care or emergency room to get evaluated. It stated he reluctantly verbalized understanding and agreed. There was no documentation to indicate the physician was notified of changes in Patient #1O's	G 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 176	Continued From page 19 condition. The Home Health Director was interviewed on 10/19/17 beginning 9:00 AM. He reviewed Patient #1O's record and confirmed there was no documentation to indicate the physician was notified of the changes in Patient #1O's condition. The RN did not inform the physician of changes in Patient #1O's condition.	G 176		
G 202	484.36 HOME HEALTH AIDE SERVICES This CONDITION is not met as evidenced by: Based on review of personnel files and agency policies, medical record review, and staff interview, it was determined the agency failed to ensure home health aides' performance was reviewed at least every 12 months, written aide plans of care were complete, aides provided and documented services as ordered, and aides' care was comprehensively assessed by an RN every 2 weeks. These factors had the potential to negatively impact the ability of the agency and the home health aides to carry out patient care in a safe, effective, and efficient manner. Findings include: 1. Refer to G214 as it relates to the failure of the agency to provide annual performance review of competencies for home health aides. 2. Refer to G224 as it relates to the failure of the agency to ensure the RN provided complete written instructions for the home health aide. 3. Refer to G225 as it relates to the failure of the	G 202	Please see G214 Plan of Correction. Please see G224 Plan of Correction. Please see G225 Plan of Correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 202	Continued From page 20 agency to ensure the home health aide provided care as ordered on the plan of care. 5. Refer to G229 as it relates to the failure of the agency to ensure comprehensive on-site home health aide supervisory visits were conducted every 14 days. The cumulative affect of these systemic practices had the potential to negatively impact safety and quality of care for patients receiving home health aide services.	G 202	Please see G229 Plan of Correction.	
G 214	484.36(b)(2)(ii) COMPETENCY EVALUATION & IN-SERVICE TRAI 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 agency personnel file review, agency policy review, and staff interview, it was determined the facility failed to ensure evaluations were conducted no less frequently than every 12 months for 1 of 1 home health aide (Staff H) employed by the agency. This had the potential to negatively impact quality and safety of patient care. Findings include: The agency's policy "HOME HEALTH AIDE COMPETENCY POLICY," reviewed and revised 9/12/17, stated "All home health aides will be observed during home visits at least yearly by an RN. Skills demonstrated at that visit will be documented in the aide's personnel file and used as data for the annual performance evaluation."	G 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEACTH	625 SOUTH ARBOR LANE, SUITE B 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 214	Continued From page 21 The agency's list of current employees included 1 Home Health Aide, Staff H, whose date of hire was 7/09/98. Her personnel file was reviewed. It included a "Home Health Aide Supplemental Checklist," dated 1/16/15, signed by the Clinical Services Manager. On 10/19/17 at 12:10 PM, the Clinical Services Manager was questioned about the frequency of aide evaluations. She stated the organization stopped doing employee evaluations a couple of years ago, but they completed an annual competency checklist for the Home Health Aide. On 10/19/17 at 1:35 PM, she presented a "Home Health Aide Supplemental Checklist" for Staff H, dated 10/04/17, signed by the Clinical Services Manager. When asked for an evaluation between the dates of 1/16/15 and 10/04/17, she stated it would have been completed by an RN who no longer worked for the agency, and she was unable to locate it. On 10/19/17 at 4:20 PM, Staff C, an RN Case Manager, presented a "Home Health Aide Supplemental Checklist" for Staff H, dated 3/23/16, signed by the Staff C. She stated she found the completed checklist in a folder in which she kept case conference notes. During an interview on 10/19/17 at 4:20 PM, Staff C stated she completed the evaluation of Staff H on 3/23/16, but had not submitted it to the Clinical Services Manager or the agency's Director. Staff C confirmed the evaluation was not reviewed by Staff H's supervisor. The agency failed to ensure the Home Health Aide's performance was reviewed at least every 12 months.	G 214	G214 484.36(b)(2)(ii) 1. Director or Clinical Manager will complete an annual evaluation form for each employed Home Health Aide between January 1st and December 31st of each calendar year. The evaluation form will include review of participation in required Home Health Aide education modules, compliance with licensure and certification requirements, and observation/review of one home visit. Documentation of the annual evaluation will be submitted to the Administrator for review. Once completed the evaluation will be kept in the employee's human resource file. 2. This will improve the processes by having a set annual date, and will keep records of this action in one location for review. 3. The Administrator, Director and Clinical Manager will be educated by November 15th 2017. 4. 2017 review completed by November 26th 2017. 5. An outlook calendar reminder will be utilized by the Director and HR Manager. 6. Implementation by Director.	
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE	G 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 224	Continued From page 22 Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on medical record review and staff interview it was determined the agency failed to ensure written patient care instructions for aides were complete for 6 of 6 patients (#1, #2, #6, #7, #9, #10) who received home health aide services, and whose records were reviewed. This resulted in the potential for patients to experience adverse outcomes. Findings include: 1. Patient #1 was a 74 year old male admitted to the agency on 9/22/17, for care following surgery to repair a fractured hip. Additional diagnoses included history of a CVA, CKD, and depression. He received SN, PT, OT, and aide services. His record, including the POC, for the certification period 9/22/17 to 11/20/17, was reviewed. Patient #1's record included an aide care plan dated 9/22/17, signed by the RN Case Manager. The care plan included sections titled "Bathing," "Skin care," and "Grooming." Each of the 3 sections stated "As per Pt request." The care plan lacked direction to the aide as to the type or frequency of care to be provided. During an interview on 10/19/17 at 9:30 AM, the Clinical Services Manager reviewed Patient #1's record and confirmed her aide care plan did not include direction to the aide regarding care to be provided.	G 224	G224 484.36(c)(1) 1. A. Frequency of each intervention will be indicated on the Aide POC. B. Fall Risk precautions, Bleeding precautions, Infectious Disease precautions, Oxygen Precautions, DME use, and any special instruction individualized to the patient will be indicated on the Aide POC. C. Instructions for wound dressing management will be indicated on the Aide POC. 2. Indicating frequency of each intervention, precautions required, DME use, and the management of wound dressings will improve clinician direction, patient and clinician safety. 3. Education to all clinicians by November 15th 2017 4. Completion by November 26th 2017 5. Director or Clinical Manager will review 100% of Aide Care Plans and Aide notes, comparing them to the most recent Oasis answers by clinicians, will be done for 90 days beginning 11/1/2017, 10% of all charts will be audited quarterly for continued compliance beginning 4/1/2018. 6. Implementation by Clinical Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 224	Continued From page 23 2. Patient #2 was a 90 year old male admitted to the agency on 10/14/17, with a primary diagnosis of pneumonia. Additional diagnoses included colon cancer with metastasis to liver and lungs. He received SN and aide services. His record, including the POC, for the certification period 10/14/17 to 12/12/17, was reviewed. Patient #2's record included an SOC comprehensive assessment dated 10/14/17, signed by the admitting RN. The assessment included the MAHC-10 Fall Risk Assessment, a validated tool to assess risk of falling in community dwelling elders, on which a score of 4 or more is considered at risk for falling. Patient #2's score was 7. Patient #2's record included an aide care plan dated 10/14/17, signed by the admitting RN. The care plan did not include information related to his increased risk of falling. During an interview on 10/19/17 at 9:45 AM, the Clinical Services Manager reviewed Patient #2's record and confirmed his aide care plan did not include direction to the aide regarding his fall risk. 3. Patient #6 was an 87 year old female admitted to the agency on 10/02/17, with a primary diagnosis of stage 2 pressure ulcers to her feet. Additional diagnoses included venous insufficiency, chronic ulcers to her legs, and obesity. She received SN, PT, OT, MSW, and aide services. Her record, including the POC, for the certification period 10/02/17 to 11/30/17, was reviewed. Patient #6's record included an SOC	G 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING ____ B. WING ____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 224	Continued From page 24	G 224		

comprehensive assessment dated 10/02/17, signed by the Clinical Services Manager. The assessment included the MAHC-10 Fall Risk Assessment. Patient #6's score was 8. Her POC included safety measures of bleeding precautions, fall precautions, and to lock her wheelchair with transfers. Additionally, her POC included orders for wound care to her BLE.

Patient #6's record included an aide care plan dated 10/02/17, signed by the Clinical Services Manager. The care plan did not include information related to bleeding precautions, or her increased risk of falling. It did not include directions related to her wounds, or the need to keep her dressings dry.

During an interview on 10/19/17 at 9:55 AM, the Clinical Services Manager reviewed Patient #6's record and confirmed her aide care plan did not include direction to the aide regarding her risks and her wounds.

4. Patient #7 was a 78 year old female admitted to the agency on 9/22/17, for care following a total knee replacement. Additional diagnoses included encephalitis, pulmonary emboli, and HTN. She received SN, PT, and aide services. Her record, including the POC, for the certification period 9/22/17 to 11/20/17, was reviewed.

Patient #7's record included an SOC comprehensive assessment dated 9/22/17, signed by the RN Case Manager. The assessment included the MAHC-10 Fall Risk Assessment. Patient #7's score was 8. Her POC included safety measures of bleeding precautions and fall precautions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 224	Continued From page 25 Patient #7's record included an aide care plan dated 9/22/17, signed by the RN Case Manager. The care plan included interventions to be completed by the aide, but it did not include the frequency of the interventions. The care plan did not include information related to bleeding precautions, or her increased risk of falling. Patient #7's aide care plan included instructions for the aide to obtain her vital signs. It did not include parameters or instructions to notify the RN Case Manager if Patient #7's vital signs were outside of normal limits. During an interview on 10/19/17 at 10:10 AM, the RN Case Manager confirmed Patient #7's aide care plan did not include the frequency interventions were to be completed, information related to bleeding precautions and fall risk, or instructions to notify the RN Case Manager of vital signs outside of normal limits. 5. Patient #9 was an 86 year old female admitted to the agency on 4/13/17, with a primary diagnosis of stage 2 pressure ulcers to her buttocks. Additional diagnoses included cervicalgia, CHF, CKD, and DM type 2. She received SN, PT, OT, MSW, and aide services. Her record, including the POC, for the certification period 4/13/17 to 6/11/17, was reviewed. Patient #9's record included an SOC comprehensive assessment dated 4/13/17, signed by the admitting RN. The assessment included the MAHC-10 Fall Risk Assessment. Patient #9's score was 9. Her POC included safety measures related to fall precautions. Patient #9's record included an aide care plan	G 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEACTH	625 SOUTH ARBOR LANE, SUITE B 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 224	Continued From page 26 dated 4/13/17, signed by the admitting RN. The care plan did not include information related to her increased risk of falling. During an interview on 10/19/17 at 10:40 AM, the Clinical Services Manager reviewed Patient #9's record and confirmed her aide care plan did not include direction to the aide regarding her fall risk. 6. Patient #10 was a 64 year old male admitted to the agency on 1/30/17, with a primary diagnosis of varicose veins of LLE with ulcer of other part of lower extremity. Additional diagnoses included wounds on the right lesser toes, lymphedema, polyneuropathy, obesity, Parkinson's disease, and major depressive disorder. He received SN, PT, and aide services. His record, including the POC, for certification period 3/31/17 to 5/29/17, was reviewed. a. The POC for certification period 3/31/17 to 5/29/17, listed safety measures. It included bleeding precautions, oxygen precautions, fall precautions, clear pathways, and use of a walker/cane. Patient #10's record included an aide care plan, dated 4/08/17, signed by the admitting RN. The aide care plan did not include any of the safety measures referenced on the POC. b. A section of the aide care plan, "Special Procedures," dated 4/08/17, directed the aide to complete "simple dressing change...change pad" and "Apply/remove suppose hose ...tubigrips." The frequency of completing these tasks was not indicated. The type of pad that was to be changed was not indicated.	G 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE 8 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 224	Continued From page 27 c. A section of the aide care plan, "Bathing," dated 4/08/17, indicated all types of bathing were to be done "per pt." The frequency was not stated. The care plan lacked specificity to guide the aide. d. The section of the aide care plan, "Skin Care," dated 4/08/17, directed the aide to "lotion," "trim non-diabetic fingernails," and "trim non-diabetic toenails." The frequency of interventions was not stated. The Home Health Director was interviewed on 10/19/17 beginning 9:00 AM. He stated the aide care plan should include safety measures and specific guidance for the aide including frequency. The agency failed to ensure aide care plans, completed by the RN, included all necessary instructions and information related to patient risks.	G 224		
G 225	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure the home health aide provided services in accordance with physician orders and the aide POC for 5 of 6 patients (#1, #6, #7, #9, and #10) who received home health aide services and	G 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 225	Continued From page 28 whose records were reviewed. This failure had the potential to interfere with the safety and quality of patient care. Findings include: 1. Patient #1 was a 74 year old male admitted to the agency on 9/22/17, for care following surgery to repair a fractured hip. Additional diagnoses included history of a CVA, CKD, and depression. He received SN, PT, OT, and aide services. His record, including the POC, for the certification period 9/22/17 to 11/20/17, was reviewed. Patient #1's record included an aide care plan dated 9/22/17, signed by the RN Case Manager. The care plan included pivot transfers to be completed with a transfer belt on every visit. His record included aide visit notes dated 9/26/17, 9/29/17, 10/03/17, 10/06/17, 10/10/17, and 10/13/17, that documented interventions provided by the aide. The aide interventions did not follow the care plan. Examples include: - Five of the 6 aide visit notes stated transfers were completed with standby assistance. They did not document use of a transfer belt. The aide visit note dated 10/10/17, did not state how transfers were performed. - The 6 aide visit notes stated "Support hose applied/removed." Application/removal of support hose was not included on the aide care plan. During an interview on 10/19/17 at 9:30 AM, the Clinical Services Manager reviewed Patient #1's aide care plan and visit notes. She confirmed interventions were not provided as ordered on the care plan. 2. Patient #6 was an 87 year old female admitted	G 225	G225 484.36(c)(2) 1. A. Aide will only complete tasks as directed on Aide POC. B. Patients unable to perform or decline assigned tasks, the Aide will call the Clinical Manager or Case Manager for direction. C. Aide will document interventions completed, declined, patient response to interventions, any change in condition, reported symptoms, reported medication changes, reported falls or injury, and any communication with Clinical Manager or Case Manager regarding the POC on the visit note or in a communication note. D. Clinical Manager or Case Manager will also document conversations and directions to Aide in a communication note. Continued next page.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 225	Continued From page 29 to the agency on 10/02/17, with a primary diagnosis of stage 2 pressure ulcers to her feet. Additional diagnoses included venous insufficiency, chronic ulcers to her legs, and obesity. She received SN, PT, OT, MSW, and aide services. Her record, including the POC, for the certification period 10/02/17 to 11/30/17, was reviewed. Patient #6's record included an aide care plan dated 10/02/17, signed by the Clinical Services Manager. Her record included 4 aide visit notes dated 10/04/17, 10/05/17, 10/11/17, and 10/13/17, that documented interventions provided by the aide. The aide interventions did not follow the care plan. Examples include: - The care plan stated to perform transfers with a sliding board on each visit. The 4 visit notes stated transfers were performed with standby assistance. They did not document use of a sliding board. - The care plan stated "Apply/remove support hose." The 4 aide visit notes did not include completion of this intervention. - The care plan stated "Brush teeth" on each visit. The 4 aide visit notes did not include completion of this intervention. During an interview on 10/19/17 at 9:55 AM, the Clinical Services Manager reviewed Patient #6's aide care plan and visit notes. She confirmed interventions were not provided as ordered on the care plan. 3. Patient #7 was a 78 year old female admitted to the agency on 9/22/17, for care following a total	G 225	G225 continued 484.36(c)(2) 2. Documentation of the visit and communication will improve Aide supervision, and patient care. 3. Education to all clinicians by November 15th 2017. 4. Completion by November 26th 2017. 5. Director or Clinical Manager will review 100% of Aide Care Plans Aide notes, Aide supervision visits, and communication notes regarding Aide services, for 90 days beginning 11/1/2017. After 90 days, 10% of all charts will be audited quarterly for compliance beginning 4/1/2018. 6. Implementation by Clinical Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE 8 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 225	Continued From page 30	G 225		

knee replacement. Additional diagnoses included encephalitis, pulmonary emboli, and HTN. She received SN, PT, and aide services. Her record, including the POC, for the certification period 9/22/17 to 11/20/17, was reviewed.

Patient #7's record included an aide care plan dated 9/22/17, signed by the RN Case Manager. Her record included 4 aide visit notes dated 9/26/17, 9/29/17, 10/03/17, and 10/06/17, that documented interventions provided by the aide. The aide interventions did not follow the care plan. Examples include:

- The care plan included "Remind to take/Assist with medications" and "Incentive Spirometer." The 4 aide visit notes did not include completion of these interventions.

- The care plan stated "Brush teeth" and "Clean dentures" on each visit. The 4 aide visit notes did not include completion of these interventions.

During an interview on 10/19/17 at 10:10 AM, the RN Case Manager reviewed Patient #7's aide care plan and visit notes. She confirmed interventions were not provided as ordered on the care plan.

4. Patient #9 was an 86 year old female admitted to the agency on 4/13/17, with a primary diagnosis of stage 2 pressure ulcers to her buttocks. Additional diagnoses included cervicalgia, CHF, CKD, and DM type 2. She received SN, PT, OT, MSW, and aide services. Her record, including the POC, for the certification period 4/13/17 to 6/11/17, was reviewed.

Patient #9's record included an aide care plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEACTH	625 SOUTH ARBOR LANE, SUITE B 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 225	Continued From page 31 dated 4/13/17, signed by the admitting RN. Her record included 5 aide visit notes dated 4/20/17, 4/25/17, 4/28/17, 5/05/17, and 5/12/17, that documented interventions provided by the aide. The aide interventions did not follow the care plan. Examples include: - The care plan stated "Apply barrier cream to clean skin on buttocks [after] shower." The 5 aide visit notes did not document completion of this intervention. - The care plan stated "Brush teeth" on each visit. The 5 aide visit notes did not include completion of this intervention. - The care plan stated "Encourage/prepare fluids." The 5 aide visit notes did not include completion of this intervention. During an interview on 10/19/17 at 10:40 AM, the Clinical Services Manager reviewed Patient #9's aide care plan and visit notes. She confirmed interventions were not provided as ordered on the care plan. 5. Patient #10 was a 64 year old male admitted to the agency on 1/30/17, with a primary diagnosis of varicose veins of LLE with ulcer of other part of lower extremity. Additional diagnoses included wounds on the right lesser toes, lymphedema, polyneuropathy, obesity, Parkinson's disease, and major depressive disorder. He received SN, PT, and aide services. His record, including the POC, for certification period 3/31/17 to 5/29/17, was reviewed. Patient #10's record included an aide care plan, dated 4/08/17, signed by the admitting RN. His	G 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEACTH	625 SOUTH ARBOR LANE, SUITE 8 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 225	Continued From page 32 record included 3 aide visit notes dated 4/18/17, 4/21/17, 4/25/17, that documented interventions provided by the aide. The aide interventions did not follow the care plan. Examples include: - The care plan stated "Respirations" on each visit. The 3 visit notes did not include completion of this intervention. - The care plan stated "Weight" on each visit. The 3 visit notes did not include completion of this intervention. - The care plan stated "Simple dressing change...Change pads." The 3 visit notes did not include completion of this task. - The care plan stated to remind patient to "Brush teeth and clean dentures" on each visit. The 3 visit notes did not include completion of these tasks. - The care plan stated "Empty trash" on each visit. The 3 visit notes did not include completion of this. The Home Health Director was interviewed on 10/19/17 beginning 9:00 AM. He stated the aide notes should indicate the care plan was followed. If it was not followed, such as patient refused, this information was to be documented. He confirmed aide notes did not reflect following Patient #1O's aide care plan. The agency failed to ensure the aide provided services as ordered on the aide care plan completed by the RN.	G 225		
G 229	484.36(d)(2) SUPERVISION	G 229		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 229	Continued From page 33 The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on medical record review, policy review, and staff interview, it was determined the agency failed to ensure the RN completed a comprehensive assessment of care provided by the home health aide every 2 weeks for 5 of 6 patients (#1, #6, #7, #9, and #10), who received aide services and whose records were reviewed. This failure had the potential to interfere with quality and safety of patient care. Findings include: The agency's policy "POLICY FOR HOME HEALTH AIDE SUPERVISION," reviewed and revised 9/12/17, stated "Supervisory visits are made to the home, at least every 14 days. The purpose of this visit is to review, evaluate and update the aide care plan. This visit is also made to evaluate the client's responses to the aide's care to to evaluate the services being delivered." 1. Patient #1 was a 74 year old male admitted to the agency on 9/22/17, for care following surgery to repair a fractured hip. Additional diagnoses included history of a CVA, CKD, and depression. He received SN, PT, OT, and aide services. His record, including the POC, for the certification period 9/22/17 to 11/20/17, was reviewed. Patient #1's record included an aide care plan dated 9/22/17, signed by the RN Case Manager.	G 229	G229 484.36(d)(2) 1. A. The clinician performing the aide supervision within the 14 day time frame will review all Aide visit notes in that supervisory time period. B. The clinician will review the Aide POC in the home with the patient or representative to receive input about the Aide's cares. C. Documentation to the performance, or lack of, will be included on the supervisory visit note. D. Aide cares that do not follow the POC will be reported to the Clinical Manager or Director. E. The Clinical Manager or Director will then document incident specific education and home supervision until standards are met. 2. This action will improve clinical supervision of Aide services, education, and clinician correction, regarding Aide POC that are not followed, and documentation of the supervisory visits. Continued next page-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 229	Continued From page 34 The care plan included pivot transfers to be completed with a transfer belt on every visit. His record included 6 aide visit notes dated 9/26/17, 9/29/17, 10/03/17, 10/06/17, 10/10/17, and 10/13/17, that documented interventions provided by the aide. The aide interventions did not follow the care plan. Examples include: - Five of the 6 aide visit notes stated transfers were completed with standby assistance. They did not document use of a transfer belt. The aide visit note dated 10/10/17, did not state how transfers were performed. - The 6 aide visit notes stated "Support hose applied/removed." Application/removal of support hose was not included on the aide care plan. Patient #1's record included SN visit notes dated 9/29/17 and 10/04/17, signed by the RN Case Manager. The visit notes stated aide supervision was completed. The notes stated the aide followed the care plan. The notes did not identify the aide's failure to use a transfer belt, or the application of support hose without an order. During an interview on 10/19/17 at 9:30 AM, the Clinical Services Manager reviewed Patient #1's supervisory visits, aide care plan, and visit notes. She confirmed the aide's failure to complete interventions as ordered on the care plan was not identified by the RN Case Manager during supervisory visits. 2. Patient #6 was an 87 year old female admitted to the agency on 10/02/17, with a primary diagnosis of stage 2 pressure ulcers to her feet. Additional diagnoses included venous insufficiency, chronic ulcers to her legs, and	G 229	G229 - Continued 484.36(d)(2) 3. All clinicians will be educated by November 15th 2017. 4. Completion date November 26th 2017. 5. Director or Clinical Manager will review 100% of Aide Care Plans Aide notes, Aide supervision visits, and communication notes regarding Aide services, for 90 days beginning 11/1/2017. After 90 days, 10% of all charts will be audited quarterly for compliance beginning 4/1/2018. 6. Implementation by Clinical Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEAUH	625 SOUTH ARBOR LANE, SUITE B 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)	(XS) COMPLETION DATE
G 229	Continued From page 35 obesity. She received SN, PT, OT, MSW, and aide services. Her record, including the POC, for the certification period 10/02/17 to 11/30/17, was reviewed. Patient #6's record included an aide care plan dated 10/02/17, signed by the Clinical Services Manager. Her record included 4 aide visit notes dated 10/04/17, 10/05/17, 10/11/17, and 10/13/17, that documented interventions provided by the aide. The aide interventions did not follow the care plan. Examples include: - The care plan stated to perform transfers with a sliding board on each visit. The 4 visit notes stated transfer were performed with standby assistance. They did not document use of a sliding board. - The care plan stated "Apply/remove support hose." The 4 aide visit notes did not include completion of this intervention. - The care plan stated "Brush teeth" on each visit. The 4 aide visit notes did not include completion of this intervention. Patient #6's record included SN visit notes dated 10/04/17 and 10/11/17, signed by the RN Case Manager. The notes stated the aide was present during the visits, and aide supervision was completed. The notes stated the aide followed the care plan. The notes did not identify the aide's failure to use a sliding board, apply/remove support hose, or brush Patient #6's teeth. During an interview on 10/19/17 at 9:55 AM, the Clinical Services Manager reviewed Patient #6's supervisory visits, aide care plan, and visit notes.	G 229		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEOED 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)	(XS) COMPLETION DATE
G 229	Continued From page 36 She confirmed the aide's failure to complete interventions as ordered on the care plan was not identified by the RN Case Manager during supervisory visits. 3. Patient #7 was a 78 year old female admitted to the agency on 9/22/17, for care following a total knee replacement. Additional diagnoses included encephalitis, pulmonary emboli, and **HTN.** She received SN, PT, and aide services. Her record, including the POC, for the certification period 9/22/17 to 11/20/17, was reviewed. Patient #7's record included an aide care plan dated 9/22/17, signed by the RN Case Manager. Her record included 4 alde visit notes dated 9/26/17, 9/29/17, 10/03/17, and 10/06/17, that documented interventions provided by the aide. The aide interventions did not follow the care plan. Examples include: - The care plan included "Remind to take/Assist with medications" and "Incentive Spirometer." The 4 aide visit notes did not include completion of these interventions. - The care plan stated "Brush teeth" and "Clean dentures" on each visit. The 4 aide visit notes did not include completion of these interventions. Patient #7's record included an SN visit note dated 9/30/17, signed by the RN Case Manager. The visit note stated aide supervision was completed. The note stated the aide followed the care plan. The note did not identify the aide's failure to address the interventions related to medications, incentive spirometer, and oral care. During an interview on 10/19/17 at 10:10 AM, the	G 229		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE 8 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)	(XS) COMPLETION DATE
G 229	Continued From page 37	G 229		

RN Case Manager reviewed Patient #7's supervisory visits, aide care plan and visit notes. She confirmed she did not identify the aide's failure to complete interventions as ordered on the care plan during her supervisory visits.

4. Patient #9 was an 86 year old female admitted to the agency on 4/13/17, with a primary diagnosis of stage 2 pressure ulcers to her buttocks. Additional diagnoses included cervicalgia, CHF, CKD, and OM type 2. She received SN, PT, OT, MSW, and aide services. Her record, including the POC, for the certification period 4/13/17 to 6/11/17, was reviewed.

Patient #9's record included an aide care plan dated 4/13/17, signed by the admitting RN. Her record included 5 aide visit notes dated 4/20/17, 4/25/17, 4/28/17, 5/05/17, and 5/12/17, that documented interventions provided by the aide. The aide interventions did not follow the care plan. Examples include:

- The care plan stated "Apply barrier cream to clean skin on buttocks [after] shower." The 5 aide visit notes did not document completion of this intervention.

- The care plan stated "Brush teeth" on each visit. The 5 aide visit notes did not include completion of this intervention.

- The care plan stated "Encourage/prepare fluids." The 5 aide visit notes did not include completion of this intervention.

Patient #9's record included SN visit notes dated 4/21/17, 4/28/17, 5/11/17, and 5/25/17 signed by the RN Case Manager. The visit notes stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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 229	Continued From page 38 aide supervision was completed. The notes stated the aide followed the care plan. The notes did not identify the aide's failure to apply barrier cream, brush teeth, and encourage/prepare fluids on each visit. During an interview on 10/19/17 at 10:40 AM, the Clinical Services Manager reviewed Patient #9's supervisory visits, aide care plan and visit notes. She confirmed the aide's failure to complete interventions as ordered on the care plan was not identified by the RN Case Manager during supervisory visits. 5. Patient #10 was a 64 year old male admitted to the agency on 1/30/17, with a primary diagnosis of varicose veins of LLE with ulcer of other part of lower extremity. Additional diagnoses included wounds on the right lesser toes, lymphedema, polyneuropathy, obesity, Parkinson's disease, and major depressive disorder. He received SN, PT, and aide services. His record, including the POC, for certification period 3/31/17 to 5/29/17, was reviewed. Patient #10's record included an aide care plan, dated 4/08/17, signed by the admitting RN. His record included 3 aide visit notes dated 4/18/17, 4/21/17, 4/25/17, that documented interventions provided by the aide. The aide interventions did not follow the care plan. Examples include: - The care plan stated "Respirations" on each visit. The 3 visit notes did not include completion of this intervention. - The care plan stated "Weight" on each visit. The 3 visit notes did not include completion of this intervention.	G 229		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137092	A. BUILDING _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEACTH	625 SOUTH ARBOR LANE, SUITE B 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 229	Continued From page 39 - The care plan stated "Simple dressing change...Change pads." The 3 visit notes did not include completion of this task. - The care plan stated to remind patient to "Brush teeth and clean dentures" on each visit. The 3 visit notes did not include completion of these tasks. - The care plan stated "Empty trash" on each visit. The 3 visit notes did not include completion of these tasks. Patient #1O's record included SN visit notes dated 4/18/17, 4/20/17, and 4/26/17 signed by the RN Case Manager. The visit notes stated aide supervision was completed. The notes stated the aide followed the care plan. The notes did not identify the aide's failure to take respirations, weight, change pads, empty trash, or remind Patient #10 to brush teeth and clean dentures. The Home Health Director was interviewed on 10/23/17 beginning 9:00 AM. He confirmed RN supervision of aides should include review of visit notes to ensure documentation indicated the plan of care was followed. The agency failed to ensure home health aide supervisory visits completed by RNs identified the aide's non-compliance with the aide care plan.	G 229		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001660	A. BUILDING:—— B. WING_____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEACTH	625 SOUTH ARBOR LANE, SUITE B 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) COMPLETE DATE
N 000	16.03.07 INITIAL COMMENTS	N 000		
N 050	03.07021. ADMINISTRATOR N050 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: d. Insuring that personnel employed shall be qualified to perform their assigned duties and that agency practices are supported by written personnel policies. This Rule is not met as evidenced by: Refer to G134	N 050	Please see response for G134. RECEIVED NOV 06 2017 FACILITY STANDARDS	
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G144	N 062	Please see response for G144.	
N 094	03.07024. SK. NSG. SERV. N094 01. Registered Nurse. A registered nurse assures that care is	N 094	Please see response for G173.	

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

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001660	A. BUILDING:—— B. WING_____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEACTH	625 SOUTH ARBOR LANE, SUITE B 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) COMPLETE DATE
N 094	Continued From page 1 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 G173	N 094		
N 118	03.07024.SK.NSG.SERV. N118 03. Home Health Aide. A home health aide must have completed the supplemental skills checklist approved by the Idaho State Board of Nursing and must be included on the Idaho State Board of Nursing's Home Health Aide Registry. Duties of a home health aide include the following: h. Completing appropriate records. This Rule is not met as evidenced by: Refer to G225	N 118	Please see response for G225.	
N 119	03.07024.04.SK.NSG.SERV. N119 04. Supervisory Visits. A registered nurse or therapist makes a supervisory visit to the patient's residence at least every two (2) weeks, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether	N 119	Please see response for G229.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001660	A. BUILDING:—— B. WING_____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE B 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) COMPLETE DATE
N 119	Continued From page 2 goals are met. For patients who are receiving only home health aide services, a supervisory visit must be made at least every sixty (60) days. This Rule is not met as evidenced by: Refer to G229	N 119		
N 122	03.07024.SK.NSG.SERV. N122 05. Training, Assignment and Instruction of A Home Health Aide. c. Written instructions for home care, including specific exercises, are prepared by a registered nurse or therapist as appropriate. This Rule is not met as evidenced by: Refer to G224	N 122	Please see response for G224.	
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	N 152	Please see response for G158.	
N 155	03.07030. PLAN OF CARE N155 01. Written Plan of Care. A	N 155	Please see response for G159.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001660	A. BUILDING:—— B. WING_____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE 8 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) COMPLETE DATE
N 155	Continued From page 3 written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: c. Types of services and equipment required; This Rule is not met as evidenced by: Refer to G159	N 155		
N 161	03.07030.PLAN OF CARE N161 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: i. Medication and treatment orders; This Rule is not met as evidenced by: Refer to G159	N 161	Please see response for G159.	
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	N 173	Please see response for G166.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	OAS001660	A. BUILDING: _____ B. WING _____	10/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCHMARK HOME HEALTH	625 SOUTH ARBOR LANE, SUITE 8 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) COMPLETE DATE
N 173	Continued From page 4 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 G166	N173		

Bureau of Facility Standards