IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN– Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
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February 14, 2020

Luke Cable, Administrator
Aspen Home Care
2867 E Copperpoint Dr
Meridian, ID 83642

RE: Aspen Home Care, Provider #137091

Dear Mr. Cable:

This is to advise you of the findings of the Medicare survey, which was concluded at your facility on January 31, 2020.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the Home Health into compliance, and that the Home Health remains in compliance

with the regulatory requirements;

- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **February 27, 2020**, and keep a copy for your records.

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, Supervisor
Non-Long Term Care

DK/nw
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137091	A. BUILDING _____ B. WING _____	01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN HOME CARE	2667 E COPPERPOINT DR MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your agency conducted on 1/28/20 to 1/31/20. Surveyors conducting the recertification survey were: Molly Lorden, RN, BSN, HFS, Team Lead Kim Mehlhaff, RN, HFS James Brown, RN, HFS Acronyms used in this report include: BG - Blood Glucose CHF - Congestive Heart Failure CKD - Chronic Kidney Disease COPD - Chronic Obstructive Pulmonary Disease DM - Diabetes Mellitus ED - Emergency Department EMR - Electronic Medical Record MSW - Medical Social Worker mg - milligram/milligrams OASIS - Outcome and Assessment Information Set OT - Occupational Therapy PA - Physician's Assistant PCP - Primary Care Physician POC - Plan of Care PT - Physical Therapy Pt - Patient ROC - Resumption of Care RNCM - Registered Nurse Case Manager SN - Skilled Nursing SOC - Start of Care	G 000	RECEIVED FEB 27 2020 FACILITY STANDARDS	
G 374	Accuracy of encoded OASIS data CFR(s): 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time	G 374		

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

Admin | 2-27-2020

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

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G 374	Continued From page 1 of assessment. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure encoded OASIS data accurately reflected patients' status at the time of assessment for 3 of 10 patients (#1, #3, and #9) whose records were reviewed. This resulted in inaccurate reporting of information. Findings include: 1. Patient #9 was a 61 year old female admitted to the agency on 1/06/20 with a primary diagnosis of sepsis. Additional diagnosis included DM type 2 and osteomyelitis. She received SN and PT services. Her record, including the POC, for the certification period 1/06/20 to 3/05/20, was reviewed. Patient #9's medical record included a "Physician Order" that was sent to the her PCP on 1/06/20 at 5:15 PM, by the RNCM. The note included the following: "The medication interaction review indicated major medication interactions for the following medications: - fluconazole - glipizide - fluconazole - oxycodone - morphine - oxycodone - morphine 15 mg oral tablet, extended release - oxycodone 5 mg oral capsule Please advise any changes in medications. Patient educated on adverse reactions, uses, drug interactions, to take medications as prescribed, not miss any doses and if they have any questions to contact their Physician." The document included the following hand-written	G 374	G374 Clinical Director will in-service all disciplines providing skilled care by 2/18/2020 on the need to ensure all OASIS data accurately reflects the patients status at the time of the assessment. Clinical Director or audit designee will audit 50% of all OASIS assessments for 5 weeks to ensure all OASIS data accurately reflects the patients status at the time of the assessment. Target Threshold is 95%. Once threshold is met will continue to audit 10% of OASIS assessments quarterly.	2/18/2020

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G 374	Continued From page 2 note in the comments section from the physician, dated 1/17/20: "Pt not seen by me since 01/2019 - one year. Medlist [medication list] does not match my records. Recommend she be seen by me for visit." There was no documentation in Patient #9's record that these potential medication interactions had been resolved. Patient #9's current medication list showed she was still on fluconazole, glipizide, morphine, and oxycodone as of 1/31/20 Patient #9's record contained an SN SOC comprehensive assessment, which included the OASIS, signed by the RNCM on 1/06/20. OASIS item M2003, indicated the agency contacted a physician (or physician-designee) by midnight of the next calendar day and completed prescribed recommended actions in response to the identified potentially clinically significant medication issues. During an interview on 1/31/20 beginning at 12:25 PM, the Clinical Manager confirmed there was no documentation in Patient #9's medical record that the agency completed the recommended actions by midnight of the next calendar day. She confirmed Patient #9's current medication list still showed she was taking the above medications. She confirmed Patient #9 had not yet seen the physician to resolve the medication concerns. The encoded OASIS data for Patient #9 as it related to M2003 was not accurate.	G 374		

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G 374	Continued From page 3 2. Patient #3 was a 70 year old male admitted to the agency on 12/09/19. He had a primary diagnosis of a non-healing surgical wound. Additional diagnoses included DM type 2 and CKD. He received PT, OT, and SN services. His record, including the POC for the certification period 12/09/19 to 2/06/20, was reviewed. Patient #3's record included an SN SOC comprehensive assessment which included the OASIS, dated 12/09/19, signed by the RNCM. Under the section titled "Endocrine/ Hematology," the document stated, "he is not checking his blood glucose levels ...The patient is not taking his insulin as per discharge instructions. He stated he only eats 2 meals a day and takes his insulin prior to those meals. Under the "MEDICATIONS" section, the document stated, "Did a complete drug regimen review identify any potential clinically significant medication issues? 0 - No - No issues found during review." The RNCM was interviewed on 1/30/20 at 12:00 PM. When asked if using insulin but not checking blood glucose was a medication issue, she confirmed the question was answered inaccurately and stated, "It is a medication issue." The RNCM failed to ensure Patient #3's OASIS data accurately reflected his status at the time of his admission to home health. 3. Patient #1 was a 73 year old male admitted to the agency on 1/02/20, with a primary diagnosis of coronary artery disease. Additional diagnoses included CKD Stage III, CHF, and DM type 2. He received PT and OT services. His record, including the POC, for the certification period 1/02/20 to 3/01/20, was reviewed.	G 374		

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G 374	Continued From page 4 Patient #1's record included a PT SOC comprehensive assessment which included the OASIS, dated 1/02/20, signed by the Physical Therapist Case Manager. The section of the assessment under "Sensory Status" documented a "2" for the OASIS question M1200. M1200 identifies Vision issues (with corrective lenses if the patient usually wears them) and an answer of a "2" indicated Patient #1's vision was "Severely impaired: cannot locate objects without hearing or touching them, or patient nonresponsive." In the section below under "Eyes/Vision," the assessment documented "Pt requires glasses for reading." The Clinical Manager was interviewed on 1/31/20 beginning at 1:10 PM, and Patient #1's SOC was reviewed in her presence. She confirmed the rating of a "2" for the M1200 OASIS question was inaccurate and should have been documented as "0 - Normal vision: sees adequately in most situations, can see medication labels, newsprint." The agency failed to ensure Patient #1's OASIS data accurately reflected his status at the time of his admission to home health.	G 374		
G 514	RN performs assessment CFR(s): 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on	G 514	G514 Clinical Director will in-service all employees by 2/18/2020 on the requirement to start home health services within 48 hours of the physician referral. Clinical Director will audit 100% of Start of Care, Resumption of Care, and Recertification for 5 weeks	2/18/2020

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G 514	Continued From page 5 the physician- ordered start of care date. This ELEMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure the initial patient assessment was performed within 48 hours of physician referral for 1 of 10 patients (Patient #2) whose records were reviewed. This failure had the potential to result in unmet patient needs. Findings include: Patient #2 was an 82 year old female with an admitting diagnosis of rhabdomyolysis. Additional diagnoses include hypertensive CKD and asthma. She received SN, PT and OT services. Her record, including the POC for the certification period 12/20/19 to 2/17/20, was reviewed. A physician referral was received by the agency on 12/18/19 stating Patient #2 needed SN, PT, and OT. It also stated Patient #2 was discharging from the hospital on 12/18/19. The SOC assessment performed by the RNCM was performed on 12/21/19, 3 days after Patient #2 was discharged from the hospital. There was no documentation as to why the initial visit was delayed. The Clinical Manager was interviewed on 1/31/20 beginning at 12:25 PM. The Clinical Manager confirmed the delayed initial visit for Patient #2 and stated she did not know the reason for the delay. The agency failed to ensure the initial visit for Patient #2 was made withing 48 hours of referral.	G 514	(continued) to ensure all care is started timely, within 48 hours of the physician referral. Target threshold is 95%. Once threshold is met, will continue to audit 10% of Start of care, resumption, and recertifications quarterly.	
G 534	Patient's needs	G 534		

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G 534	Continued From page 6 CFR(s): 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; This ELEMENT is not met as evidenced by: Based on review of medical records and staff interview, it was determined the agency failed to identify relevant social work needs for 2 of 10 patients (#3 and #8) whose records were reviewed. This had the potential to result in unmet patient needs. Findings include: 1. Patient #3 was a 70 year old male admitted to the agency on 12/09/19. He had a primary diagnosis of a non-healing surgical wound. Additional diagnoses included DM type 2 and CKD. He received PT, OT, and SN services. His record, including the POC for the certification period 12/09/19 to 2/06/20, was reviewed. Patient #3's record included an SN SOC comprehensive assessment, dated 12/09/19, signed by the RNCM. Under the section titled "Respiratory," the document stated, "Patient educated to continue to use CPAP [continuous positive airway pressure] as ordered during sleep but he stated that it was broken and hasn't been used in years." The RNCM was interviewed on 1/30/20 at 12:00 PM. When asked how Patient #3 was educated to continue to use his broken CPAP, the RNCM stated Patient #3 refused to get his CPAP fixed. The RNCM also stated Patient #3 could not afford to get his CPAP fixed. When asked if Patient #3 was offered a social worker to assist him with funding for his CPAP machine, the RNCM stated she offered him a social worker and he refused.	G 534	G534 Clinical Director will in-service all employees by 2/18/2020 on how to recognize social work needs and when to seek a physician order to start social work services. Will inservice all staff on identifying and caring for the pateint's medical, nursing, rehabilitative, social, and discharge planning needs. Clinical Director will audit 75% of all active and new referrals for 5 weeks to ensure all medical, nursing, rehabilitative, social, and discharge planning needs are met. Target threshold is 95%. Once threshold is met, will continue to audit 10% of charts quarterly.	2/18/2020

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G 534	Continued From page 7 The Clinical Manager was interviewed on 1/31/20 at 10:20 AM. She was unable to find documentation Patient #3 was offered and refused a social worker. Patient #3's social work needs were not identified on or after his SOC. 2. Patient #8 was a 54 year old female admitted to the agency on 12/23/19, with a primary diagnosis of pneumonia. Additional diagnoses included COPD, acute respiratory failure with hypoxia, DM type 2, CKD stage 4, and chronic pain. She received SN, PT, and OT services. Her record, including the POC, for the certification period 12/23/19 to 2/20/20, was reviewed. Patient #8's record included an SN SOC comprehensive assessment, dated 12/23/19, signed by the RNCM. The SOC identified the need for an MSW referral as follows: "Living Arrangements: Community Resource Info needed to manage care Yes. Altered affect (i.e. depression, grief, body image, chg.) Yes. Risk Factors: -Non Compliance with medication regimen -Low socioeconomic status or financial concerns -Inadequate support network -Home safety risks -Confusion -Depression" The RNCM was interviewed on 1/30/20 beginning at 10:00 AM by telephone and Patient #8's record was reviewed. She confirmed the MSW needs that were identified and confirmed she should have requested an MSW referral from the	G 534		

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G 534	Continued From page 8 physician. The agency failed to ensure Patient #8's social work needs were met.	G 534		
G 536	A review of all current medications CFR(s): 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This ELEMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure medications and allergies were reconciled at the time of admission for 1 of 10 patients (Patient #1) whose records were reviewed. This had the potential to compromise patient safety. Findings include: Patient #1 was a 73 year old male admitted to the agency on 1/02/20, with a primary diagnosis of coronary artery disease. Additional diagnoses included CKD Stage III, CHF and DM type 2. He received PT and OT services. His record, including the POC, for the certification period 1/02/20 to 3/01/20, was reviewed. Patient #1's record included referral information with a list of current medications and allergies, dated 12/27/19, which included lisinopril as an allergy. Patient #1's "Individual Emergency Plan," signed by him at the SOC also listed lisinopril as an allergy. Patient #1's PT SOC comprehensive	G 536	G536 Clinical Director will in-service all employees by 2/18/2020 on the need to review all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Clinical Director or audit designee will audit 75% of patient medication lists/reviews for 5 weeks to ensure all medications the patient is currently using identifies any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Target threshold is 95%. Once threshold is met will continue to audit 10% of patient medication lists/reviews quarterly.	2/18/2020

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G 536	Continued From page 9 assessment, completed by a Physical Therapist, and his record listed "No Known Allergies." The Clinical Manager was interviewed on 1/31/20 beginning at 1:10 PM, and Patient #1's record was reviewed in her presence. She confirmed the missing allergy in Patient #1's record. Patient #1's allergy profile was not accurate or reconciled.	G 536		
G 572	Plan of care CFR(s): 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. This STANDARD is not met as evidenced by: Based on medical record review, observation, and staff interview, it was determined the agency failed to ensure patients received home health services in accordance with an individualized plan of care for 3 of 10 patients (#1, #3 and #7) whose records were reviewed. This had the potential to interfere with quality and safety of patient care. Findings include: 1. Patient #7 was an 84 year old female admitted to the agency on 8/23/19. She had a primary diagnosis of CKD with CHF. Additional	G 572	G572 Clinical Director will in-service all employees by 2/18/2020 on the need to ensure all patients receive the home health services that are written in an individualized plan of care that identifies patient-specific measureable outcomes and goals, and signed by a doctor of medicine, osteopathy, or podicatry acting within the scope of his or her state license, certification, or registration. If a physician refers a patient under a plan of care that cannont be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Clinical Director or audit designee will audit 100% of all 485/plans of care for 5 weeks to ensure the patient receives the home health services that are	2/18/2020

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G 572	Continued From page 10 diagnoses included COPD and atrial fibrillation. She received SN, PT, and OT services. Her record, including the POC, for the certification period 8/23/19 to 10/21/19, was reviewed. She was discharged from the agency on 9/13/19 after she died in a hospital. Patient #7's record included a document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 8/23/19, signed by the RNCM. The document stated, "Agency/patient to report any weight gain of 3 pounds in a 24 hour period or 5 pounds in a 5 day period to the physician." Patient #7's record included a PT visit note, dated 8/27/19, signed by the Physical Therapist. The note listed Patient #7's weight as 147 pounds. Patient #7's record included a PT visit note, dated 8/31/19, signed by the Physical Therapist. The note listed Patient #7's weight as 152 pounds, a 5 pound weight gain in 4 days. The note did not indicate Patient #7's physician was notified of the weight gain. The Clinical Manager was interviewed on 1/31/20 at 10:40 AM. When asked if it was her expectation therapy staff should notify physicians of changes as ordered on the POC, she stated therapy should report changes to SN or the physician. She was unable to find documentation the Physical Therapist notified SN or Patient #7's physician of the weight gain. Patient #7's physician was not notified of weight gain as ordered in the POC. 2. Patient #3 was a 70 year old male admitted to the agency on 12/09/19. He had a primary	G 572	(G572 continued) written in an individualized plan of care that identifies patient-specific measureable outcomes and goals, and signed by a doctor of medicine, osteopathy, or podicatry acting within the scope of his or her state license, certification, or registration. If a physician refers a patient under a plan of care that cannont be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Target threshold is 95%. Once threshold is met, will continues to audit 10% of 485/plans of care quarterly.	

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G 572	Continued From page 11 diagnosis of a non-healing surgical wound. Additional diagnoses included DM type 2 and CKD. He received PT, OT, and SN services. His record, including the POC for the certification period 12/09/19 to 2/06/20, was reviewed. Patient #3's record included a document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 12/09/19, signed by the RNCM. The document stated, "Instruct Pt/Caregiver on use of glucometer including frequency, calibration, and recording results." Patient #3's record included an SN SOC comprehensive assessment, dated 12/09/19, signed by the RNCM. Under the section titled "Primary Diagnosis & Other diagnoses," DM type 2 was listed as a severity code of 2, meaning symptoms were controlled with difficulty and Patient #3 needed ongoing monitoring. Under the section titled "Endocrine/ Hematology," the note stated, "The patient stated that he can't find his glucometer so he is not checking his blood glucose levels." Patient #3's record did not document how the RNCM was instructing Patient #3 to use his glucometer since he could not locate his glucometer. A visit to Patient #3's home was made on 1/29/20 beginning at 9:30 AM. During the visit, Patient #3 said he had his glucometer but it was not working. The RNCM was interviewed on 1/30/20 at 12:00 PM. She stated Patient #3 was non-compliant with checking blood glucose. When asked if she looked at Patient #3's glucometer, she said she did not look at it and that was an "error on my part." She stated she needed to look at the	G 572		

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	137091	A. BUILDING _____ B. WING _____	01/31/2020

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ASPEN HOME CARE	2867 E COPPERPOINT DR MERIDIAN, ID 83642

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G 572	Continued From page 12 glucometer because it was "usually just the battery." Patient #3 was not instructed on the use of his glucometer as ordered in his POC. 3. Patient #1 was a 73 year old male admitted to the agency on 1/02/20, with a primary diagnosis of coronary artery disease. Additional diagnoses included CKD Stage III, CHF and DM type 2. He received PT and OT services. His record, including the POC, for the certification period 1/02/20 to 3/01/20, was reviewed. Patient #1's record included a referral that indicated the need for nursing services. The agency's Patient Information sheet indicated orders had been received for SN services, but a visit by an SN had not been made by the time of the surveyors home visit on 1/29/20. The Clinical Manager was interviewed on 1/31/20 beginning at 1:10 PM, and Patient #1's record was reviewed in her presence. She confirmed SN was ordered on the referral, but could not determine why an SN visit had not been made. Patient #1's did not receive SN services as ordered by the referring physician.	G 572		
G 574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and	G 574	G574 Clinical Director will in-service all employees by 2/18/2020 to ensure the individualized plan of care includes the following:	2/18/2020

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G 574	Continued From page 13 equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. This ELEMENT is not met as evidenced by: Based on review of medical records, staff interview, observations, and website review, it was determined the agency failed to ensure the POC was accurate and included all pertinent diagnoses, medications, allergies, interventions, and goals for 3 of 10 patients (#1, #3, and #8) whose records were reviewed. This resulted in incomplete POCs and had the potential for unmet patient needs. Findings include: 1. Patient #1 was a 73 year old male admitted to the agency on 1/02/20, with a primary diagnosis of coronary artery disease. Additional diagnoses included CKD Stage III, CHF and DM type 2. He received PT and OT services. His record,	G 574	(G574 continued) (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. Clinical Director or audit designee will audit 100% of 485/plans of care for 5 weeks to ensure the individualized plan of care includes:	

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G 574	Continued From page 14 including the POC, for the certification period 1/02/20 to 3/01/20, was reviewed. A home visit was made to Patient #1's residence on 1/29/20 beginning at 11:16 AM, to observe an OT visit. Patient #1's agency medication list was reviewed in the spouse's and OT's presence. The following discrepancies were noted: - Patient #1's medication list included elemental iron and spironolactone. His spouse reported these 2 medications had been discontinued "for several weeks." - Patient #1's medication list included gabapentin and potassium chloride. His spouse reported these 2 medications were on hold and had been "for several weeks." - Patient #1's medication list included Bumetanide twice a day. His spouse reported the current prescription was once daily. The Clinical Manager was interviewed on 1/31/20 beginning at 1:10 PM, and during the interview she was informed of the discrepancies between the agency's medication profile and what was being taken in the home. She stated her expectation was for all patients to have an accurate and current medication profile. The agency failed to ensure Patient #1 had an accurate medication profile. 2. Patient #8 was a 54 year old female admitted to the agency on 12/23/19, with a primary diagnosis of pneumonia. Additional diagnoses included COPD, acute respiratory failure with hypoxia, DM type 2, CKD stage 4 and chronic	G 574	(G574 continued) (I) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. Target threshold is 95%. Once threshold is met will continue to monitor 10% of 485/plans of care quarterly.	

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G 574	Continued From page 15 pain. She received SN, PT, and OT services. Her record, including the POC, for the certification period 12/23/19 to 2/20/20, was reviewed. Patient #8's record included an SN SOC comprehensive assessment, dated 12/23/19, signed by the RNCM. The POC included wound care orders for Patient #8's amputated toe. The wound care orders included, "Instruct/perform wound care as follows: apply Isosorbide gel to the surgical site twice weekly." According to the website MedlinePlus.gov, accessed on 2/13/20, Isosorbide is a heart medication and not available in gel form (retrieved from https://medlineplus.gov/druginfo/meds/a682348.html). The RNCM was interviewed on 1/30/20 beginning at 10:00 AM by telephone and Patient #8's documentation was reviewed. She confirmed the order written for wound care was incorrect. The RNCM confirmed she was actually using Iodosorb gel which is a commonly used medication used to clean and promote healing of wounds. Patient #8's wound care orders included an incorrect wound care medication. 3. Patient #3 was a 70 year old male admitted to the agency on 12/09/19. He had a primary diagnosis of a non-healing surgical wound. Additional diagnoses included DM type 2 and CKD. He received PT, OT, and SN services. His record, including the POC for the certification period 12/09/19 to 2/06/20 was reviewed. An SN home visit at Patient #3's residence was observed on 1/29/20 beginning at 9:30 AM.	G 574		

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G 574	Continued From page 16 Patient #3's agency medication list was reviewed in his presence after the home visit was completed at 10:35 AM. The medication list was compared with Patient #3's physician ordered POC. The following discrepancies were noted: - Patient #3's medication list and POC included amlodipine, a medication used to regulate blood pressure, one 5mg oral tablet twice daily. Patient #3 stated he took one 5 mg oral tablet once daily. - Patient #3's medication list and POC included sotalol, a medication used to regulate heart rate, one 40 mg tablet twice daily. Patient #3 said he took ½ of the 40 mg tablet twice daily. - Patient #3's medication list and POC included Toujeo SoloStar, a medication used to regulate blood sugar, 35 units subcutaneous at bedtime. Patient #3 stated he took 40 units subcutaneous at bedtime. The Clinical Manager was interviewed on 1/31/20 at 10:20 AM and the medication discrepancies identified in Patient #3's home were reviewed in her presence. She confirmed the above discrepancies and agreed the POC did not match the doses and frequencies of medications Patient #3 was taking. Patient #3 was not taking medications as ordered by the physician.	G 574		
G 590	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes	G 590	G590 Clinical Director will in-service all employees by 2/18/2020 on need to ensure that the home health agency promptly alerts the relevant physician(s)	2/18/2020

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G 590	Continued From page 17 are not being achieved and/or that the plan of care should be altered. This ELEMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure physicians were promptly alerted to changes in patients' conditions or needs that suggested a need to alter the POC for 2 of 10 patients (#3 and #10) whose records were reviewed. This had the potential to result in unaddressed patient conditions and needs. Findings include: 1. Patient #10 was a 50 year old female admitted to the agency on 1/09/20, for care following an amputation. Additional diagnoses included DM type 2, cellulitis of left lower limb, and multiple sclerosis. She received SN, PT, and OT services. His record, including the POC, for the certification period 1/09/20 to 3/08/20, was reviewed. Patient #10's record included an SN SOC comprehensive assessment, dated 1/09/20, signed by the RNCM, which included a depression screening. The screening included the following questions: "Over the last two weeks, how often have you been bothered by any of the following problems?" - "Little interest or pleasure in doing things" - "Feeling down, depressed, or hopeless" Patient #10 responded "Not at all" to both questions. Patient #10's medical record included an SN visit	G 590	(G590 continued) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Clinical Director or audit designee will audit 75% of active patients and new admits for 5 weeks to ensure that the home health agency promptly alerts the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Target threshold is 95%. Once threshold is met, will continue to monitor 10% of patient charts quarterly.	

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G 590	Continued From page 18 note, dated 1/21/20, signed by the RNCM. Under the section of the visit note titled "emotional status" the box for "depressed" was checked. The note documented: "[Patient] was tearful 1/20 with concerns. Has heard her deceased son and MIL's [mother in law] voices. Believes she has been stressed and is grieving the loss of her son who died 3 years ago. Says she has lost the joy in doing things most days ... She [patient] is going to ask [provider name], PA for a script [prescription] for an antidepressant; she did make the call today, but unable to connect due to PA being out of the office." There was no documentation Patient #10's physician was notified of her change in status related to her depression. The Clinical Manager was interviewed 1/31/20 beginning at 12:25 PM, and Patient #10's medical record was reviewed in her presence. She confirmed there was no documentation Patient #10's physician was notified of her change in status. She stated Patient #10's physician should have been notified about the change in her condition. The agency failed to ensure the physician was alerted to Patient #10's new depression. 2. Patient #3 was a 70 year old male admitted to the agency on 12/09/19. He had a primary diagnosis of a non-healing surgical wound. Additional diagnoses included DM type 2 and CKD. He received PT, OT, and SN services. His record, including the POC for the certification period 12/09/19 to 2/06/20, was reviewed.	G 590		

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G 590	Continued From page 19 Patient #3's record included a document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE," dated 12/09/19, signed by the RNCM. The document stated, "Instruct Pt/Caregiver on use of glucometer including frequency, calibration, and recording results." Patient #3's record included an SN SOC comprehensive assessment, dated 12/09/19, signed by the RNCM. Under the section titled "Primary Diagnosis & Other diagnoses," DM type 2 was listed as a severity code of 2, meaning symptoms were controlled with difficulty and Patient #3 needed ongoing monitoring. Under the section titled "Endocrine/ Hematology," the note stated, "The patient stated that he can't find his glucometer so he is not checking his blood glucose levels." The RNCM was interviewed on 1/30/20 at 12:00 PM. She stated Patient #3 was non-compliant with checking blood sugars. She stated Patient #3's physican was aware he was not checking his blood glucose. The Clinical Manager was interviewed on 1/31/20 at 10:20 AM. She was unable to find documentation that Patient #3's physician was notified he was not checking his blood glucose. Patient #3's physician was not notified he was not taking his blood glucose, suggesting a need to alter the POC.	G 590		
G 604	Integrate all orders CFR(s): 484.60(d)(2) Integrate orders from all physicians involved in	G 604		

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G 604	Continued From page 20 the plan of care to assure the coordination of all services and interventions provided to the patient. This ELEMENT is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to sufficiently coordinate patient services and interventions for 1 of 10 patients (Patient #1) whose records were reviewed. This resulted in a lack of physician involvement to resolve a patient's medication interaction concerns. Findings include: 1. Patient #9 was a 61 year old female admitted to the agency on 1/06/20 with a primary diagnoses of sepsis. Additional diagnosis included, DM type 2, and osteomyelitis. She received SN and PT services. Her record, including the POC, for the certification period 1/06/20 to 3/05/20, was reviewed. Patient #9's medical record included a "Physician Order" that was sent to Patient #9's PCP on 1/06/20 at 5:15 PM, by the RNCM. The note included the following: "The medication interaction review indicated major medication interactions for the following medications: - fluconazole - glipizide - fluconazole - oxycodone - morphine - oxycodone - morphine 15 mg oral tablet, extended release - oxycodone 5 mg oral capsule Please advise any changes in medications. Patient educated on adverse reactions, uses, drug interactions, to take medications as prescribed, not miss any doses and if they have any questions to contact their Physician"	G 604	G604 Clinical Director will in-service all employees by 2/18/2020 on need to integrate orders from all physicians involved in the plan of care to assure the coordination of all services and interventions provided to the patient. Clinical Director or audit designee will audit 50% of all orders and 485/plans of care for 5 weeks to ensure the agency integrates orders from all physicians involved in the plan of care to assure the coordination of all services and interventions provided to the patient. Target threshold is 95%. Once threshold is met will continue to audit 10% of orders quarterly.	2/18/2020

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G 604	Continued From page 21 The document included the following hand-written note in the comments section from the physician, dated 1/17/20: "Pt not seen by me since 01/2019 - one year. Medlist [medication list] does not match my records. Recommend she be seen by me for a visit." There was no documentation in Patient #9's record that these potential medication interactions had been resolved. Patient #9's current medication list showed she was still on fluconazole, glipizide, morphine, and oxycodone. During an interview on 1/31/20 beginning at 12:25 PM, the Clinical Manager confirmed there was no documentation in Patient #9's medical record that the agency completed the recommended actions from the physician, and Patient #9 was still currently taking the medications listed on the interaction list. She confirmed Patient #9 had not yet seen the physician to resolve the medication concerns. The agency failed to ensure Patient #9's medication interaction concerns were resolved.	G 604		
G 616	Patient medication schedule/instructions CFR(s): 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. This ELEMENT is not met as evidenced by:	G 616	G616 Clinical Director will in-service all employees by 2/18/2020 of need to ensure patient medication schedule/ instructions, including: medication name, dosage and frequency and which medications will be administered by home health agency personnel and	2/18/2020

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G 616	Continued From page 22 Based on observation, record review, patient representative and staff interview, it was determined the agency failed to ensure a written medication schedule/instructions was provided to patients for 1 of 4 patients (Patient #1) whose home visits were observed and whose records were reviewed. This resulted in patients not having access to their medication lists. Findings include: Patient #1 was a 73 year old male admitted to the agency on 1/02/20, with a primary diagnosis of coronary artery disease. Additional diagnoses included CKD stage III, CHF and DM type 2. He received PT and OT services. His record, including the POC, for the certification period 1/02/20 to 3/01/20, was reviewed. A visit was made to Patient #1's home on 1/29/20 beginning at 11:16 AM, to observe an OT visit. A copy of the agency's medication schedule/instructions were requested from the patient's spouse in the presence of the OT. The spouse reported that she had never received a copy of a medication schedule/instructions from the agency and used a medication list provided from another care provider. The Clinical Manager was interviewed on 1/31/20 beginning at 1:10 PM, and during the interview she was informed a medication list was not present in Patient #1's home. She stated her expectation was for all patients to have a current medication schedule/instructions in their homes. The agency failed to ensure Patient #1 received a list of his current medications.	G 616	(G616 continued) personnel acting on behlf of the home health agency. Clinical Director or audit designee will audit 75% of active and new patients charts to ensure patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by home health agency personnel and personnel acting on behlf of the home health agency is present in the chart. Target threshold is 95%. Once threshold is met, will continue to monitor 10% of charts quarterly.	
G 622	Name/contact information of clinical manager	G 622		

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ASPEN HOME CARE	2867 E COPPERPOINT DR MERIDIAN, ID 83642

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G 622	Continued From page 23 CFR(s): 484.60(e)(5) Name and contact information of the HHA clinical manager. This ELEMENT is not met as evidenced by: Based on observation and patient representative and staff interview, it was determined the agency failed to ensure written disclosure of the Clinical Manager's name and contact information was provided to 1 of 10 patients (Patient #1) whose home health records were reviewed. This failure had the potential for a patient and their representative to be unaware of who to contact for care concerns and/or complaints. Findings include: A visit was made to Patient #1's home on 1/29/20 beginning at 11:16 AM, to observe an OT visit. An admission packet containing the Clinical Manager's name and contact information was not located in the patient home. The spouse reported not receiving an admission packet from the agency. The OT confirmed the packet containing the Clinical Manager's name and contact information was not located in Patient #1's home. The Clinical Manager was interviewed on 1/31/20 beginning at 1:10 PM, and during the interview she was informed an admission packet was not present in Patient #1's home. She stated her expectation was for all patients to have an admission packet that had the Clinical Manager's name and contact information. The agency failed to ensure written disclosure of the Clinical Manager's name and contact information was provided to patients and their representatives.	G 622	G622 Clinical Director will in-service all employees by 2/18/2020 on need to ensure that the name and contact information of the home health agency clinical manager is provided to the patient. Clinical Director or audit designee will audit 75% of active and new patients charts to ensure that the name and contact information of the home health agency clinical manager is provided to the patient. Target threshold is 95%. Once threshold is met, will continue to monitor 10% of patient records.	2/18/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137091	A. BUILDING _____ B. WING _____	01/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 716	Continued From page 24	G 716		
G 716	Preparing clinical notes CFR(s): 484.75(b)(6) Preparing clinical notes; This ELEMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined, the agency failed to ensure clinical notes were complete and accurate for 1 of 10 patients (Patient #1) whose records were reviewed. This had the potential to interfere with quality and coordination of patient care. Findings include: Patient #1 was a 73 year old male admitted to the agency on 1/02/20, with a primary diagnosis of coronary artery disease. Additional diagnoses included CKD Stage III, CHF and DM type 2. He received PT and OT services. His record, including the POC, for the certification period 1/02/20 to 3/01/20, was reviewed. Patient #1's record included an SN SOC comprehensive assessment, dated 1/02/20, signed by the Physical Therapist Case Manager. The OASIS question for urinary incontinence was documented as "0 - No incontinence or catheter." The narrative section under "Genitourinary" stated, "Pt educated on signs and symptoms of genitourinary complications and when to contact a physician. Discussed timed voiding, she states that does not stop the stress incontinence." The Clinical Manager was interviewed on 1/31/20 beginning at 1:10 PM, and Patient #1's record was reviewed in her presence. She confirmed the note did not accurately reflect Patient #1's status. She confirmed the agency's EMR allowed for clinicians to copy forward and/or copy/paste and stated agency expectations were to	G 716	G716 Clinical Director to in-service all employees by 2/18/2020 on need to ensure that the clinical notes are prepared correctly and that the clinical notes are complete and accurate. Clinical Director or audit designee will audit 75% of active and new patients for 5 weeks to ensure that the clinical notes are complete and accurate. Target threshold is 95%. Once threshold is met, will continue to monitor 10% of patient charts quarterly.	2/18/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 716	Continued From page 25 Individualize the clinical notes to the patients current status at the time of visit. Clinical notes for Patient #1 did not accurately reflect his status.	G 716		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 000	Initial Comments A survey of Emergency Preparedness, was conducted on 2/13/19. Aspen Home Care is in complaince with 42 CFR 484.102. Molly Lorden, RN, BSN, HFS - Team Lead James Brown, RN, HFS	E 000	RECEIVED FEB 27 2020 FACILITY STANDARDS	

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

Admin 2-27-2020

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.