COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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March 3, 2020

Kelly Spiers, Administrator
Visions Home Health & Visions Home Care LLC
455 Park View Loop
Twin Falls, ID 83301

RE: Visions Home Health & Visions Home Care LLC, Provider #137107

Dear Mr. Spiers:

On February 20, 2020, an on-site follow-up revisit was conducted to verify that Visions Home Health & Visions Home Care LLC was in compliance with all Conditions of Participation. The agency's allegation of compliance indicated your agency was in substantial compliance as of February 23, 2020. However, based on our on-site revisit conducted February 20, 2020, your agency remains out of compliance with the following Condition of Participation:

- Care Planning, Coordination, Quality of Care (42 CFR 484.60)

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

The deficiencies, which caused the condition to be unmet, substantially limit the capacity of Visions Home Health & Visions Home Care LLC to furnish services of sufficient level and quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567).

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 the federal 2567 form.**

Please complete your Allegation of Compliance/Plan of Correction and submit it to this office by **March 13, 2020**. It is strongly recommended that the agency's Credible Allegation/Plan of Correction for the Condition of Participation and related standard level deficiences show compliance no later than **March 23, 2020**. 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 were recommended to the Centers for Medicare/Medicaid (CMS) Region X Office, following the December 16, 2019 validation survey of your agency:

- Termination [42 CFR 488.865]

You were notified of this recommendation in the CMS January 9, 2020 letter, sent following the December 16, 2019 validation survey.

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.

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, Supervisor
Non-Long Term Care

DK/ac
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/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137107	A. BUILDING _____ B. WING _____	R 02/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISIONS HOME HEALTH & VISIONS HOME CARE LLC	455 PARK VIEW LOOP TWIN FALLS, ID 83301

(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 follow up survey of your agency conducted on 2/18/20 through 2/20/20. Surveyors conducting the follow-up survey were: Weslianne Lewis, RN, BSN, HFS - Team Lead Molly Lorden, RN, BSN, HFS Acronyms used in this report include: AFib - Atrial Fibrillation ALF - Assisted Living Facility CHF - Congestive Heart Failure CKD - Chronic Kidney Disease COPD - Chronic Obstructive Pulmonary Disease DM - Diabetes Mellitus HFS - Health Facilities Surveyor HHA - Home Health Agency HTN - Hypertension lbs - Pounds LPN - Licensed Practical Nurse mg - Milligram OASIS - Outcome and Assessment Information Set OT - Occupational Therapy OTC - Over the Counter oz - Ounces PCP - Primary Care Physician POC - Plan of Care Pt/pt - Patient PT - Physical Therapy PTA - Physical Therapist Assistant RN - Registered Nurse RNCM - Registered Nurse Case Manager SN - Skilled Nursing ST - Speech Therapy	{G 000}	RECEIVED MAR 11 2020 FACILITY STANDARDS	
{G 570}	Care planning, coordination, quality of care	{G 570}		

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

Administrator 3-09-2020

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 570}	Continued From page 1 CFR(s): 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. This CONDITION is not met as evidenced by: Based on observation, medical record review, policy review, chart audit review, patient interview, and staff interview, it was determined the agency failed to ensure care and treatments followed the patient's individualized POC, POCs were accurate and included all pertinent information, physicians were promptly alerted to changes in patient condition, and care was coordinated to meet the patient's needs. These failures had the potential to result in unmet patient needs and negatively impact the continuity, safety, and quality of patient care. Findings include: 1. Refer to G572, as it relates to the failure of the agency to ensure care followed patients' individualized POC.	{G 570}		

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{G 570}	Continued From page 2 2. Refer to G574, as it relates to the failure of the agency to ensure POC's were accurate and included all pertinent information. 3. Refer to G590, as it relates to the failure of the agency to promptly alert physicians to changes in the patient's conditions or needs. 4. Refer to G608, as it relates to the failure of the agency to ensure care delivery was coordinated to meet the patient's needs.	{G 570}		
{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, agency policy review, 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 5 of 10 patients (#5, #6, #7, #8, and #9) whose home health records were reviewed. This had the potential to interfere with quality and safety of patient care. Findings include:	{G 572}		

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{G 572}	Continued From page 3 1. Patient #5 was an 80 year old female admitted to the agency on 2/03/20, with a primary diagnosis of laceration of scalp. Additional diagnoses included HTN, DM type 2, and AFib. She received PT services. Her record, including the POC, for the certification period 2/03/20 to 4/02/20, was reviewed. Patient #5's POC included an order to "Monitor weight and assess for weight change." Her record included an SOC OASIS, dated 2/03/20, signed by the Physical Therapist. The note included Patient #5's weight as 180 pounds. Her record included 2 PT visit notes during week 2 of her certification period, dated 2/10/20 and 2/13/20. The notes did not include documentation of Patient #8's weight. The Clinical Manager was interviewed on 2/19/20, beginning at 3:57 PM, and Patient #5's record was reviewed in her presence. She stated it was the agency's expectation that patients be weighed at least once each week. She confirmed Patient #5's weight was not monitored during week 2 of her certification period. Patient #5's weight was not monitored as ordered on her POC. 2. Patient #8 was a 71 year old female admitted to the agency on 2/05/20, with a primary diagnosis of malignant neoplasm of lung. Additional diagnoses included secondary malignant neoplasm of brain and COPD. She received SN and Aide services. Her record, including the POC, for the certification period 2/05/20 to 4/04/20, was reviewed. Patient #8's POC included an SN order to	{G 572}		

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{G 572}	Continued From page 4 "Monitor weight." Her record included one SN visit note during week 2 of her certification period, dated 2/12/20. The note did not include documentation of Patient #8's weight. The Clinical Manager was interviewed on 2/19/20, beginning at 3:57 PM, and Patient #8's record was reviewed in her presence. She stated it was the agency's expectation that patients be weighed at least once each week. She confirmed Patient #8's weight was not documented during week 2 of her certification period. Patient #8's weight was not monitored as ordered on her POC. 3. Patient #9 was a 71 year old female admitted to the agency on 11/22/19, with a primary diagnosis of DM type 2 foot ulcer. Additional diagnoses included CHF, CKD, and DM type 2. She received SN and PT services. Her record, including the POC, for the certification period 1/21/20 to 3/20/20, was reviewed. An agency policy titled, "MISSED VISITS," dated December 2018, stated, "Missed visits will be communicated to the clinical supervisor and the patient's physician." This policy was not followed. An example includes: Patient #9's POC included an order for PT services 1 time per week for 1 week, then 2 times per week for 3 weeks, effective 1/23/20. Patient #9's record included a PT Visit Note, dated 2/12/20, signed by the PTA, which documented Patient #9 refused the PT visit and the visit was not rescheduled. There was no documentation Patient #9's physician was notified	{G 572}		

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{G 572}	Continued From page 5 of the missed visit. The PTA was interviewed on 2/20/20, beginning at 8:33 AM. She stated she notified only the PT supervisor and the RNCM of Patient #9's missed visit on 2/12/20. The agency failed to notify Patient #9's physician she did not receive a PT visit as ordered. 4. Patient #7 was a 91 year old male admitted to the agency on 2/04/20, with a primary diagnosis of pneumonia. An additional diagnosis included chronic pain. He received PT and OT services. His record, including the POC, for the certification period 2/04/20 to 4/03/20, was reviewed. Patient #7's POC stated, "The patients [sic] physician should be called for weight gain/loss of 3 pounds in 24 hours or 5 pounds in 7 days." This order was not followed. An example includes: Patient #7's record included a PT SOC OASIS, dated 2/04/20, signed by the Physical Therapist. The note documented Patient #7's weight as 167 lbs. Patient #7's record included an OT visit note, dated 2/05/20, signed by the Occupational Therapist. The noted documented Patient #7's weight as 163 lbs 4oz, indicating a 3 lb 12 oz weight loss in 24 hours. The note did not include documentation that Patient #7's physician was notified of his weight loss as ordered on the POC. The Occupational Therapist was interviewed by phone on 2/19/20 at 4:38 PM. When asked if he reported Patient #7's 3 lb 12 oz weight loss to his	{G 572}		

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{G 572}	Continued From page 6 physician, the Occupational Therapist stated, "I didn't do it," and, "I should have." The Occupational Therapist did not notify Patient #7's physician of his 3 lb 12 oz weight loss as ordered on the POC. 5. Patient #6 was a 25 year old male admitted to the agency on 9/11/17, with a primary diagnosis of a traumatic brain injury. Additional diagnoses included dysphagia and chronic pain. He received ST and PT. His record, including the POC, for the certification period 12/30/19 to 2/27/20, was reviewed. Patient #6's record included a "Physician Order," dated 2/03/20, signed by the RNCM. It was signed by Patient #6's physician on 2/05/20. The order stated, "SN/Therapist to O/A [observe/assess] VS [vital signs], Systems, PRN Sp02 [as needed oxygen saturation], pain, and Medication Regime ...S/Sx [signs/symptoms] to report. Respiratory rate of <10 or >26 Pulse rate of <50 or >110 Systolic Blood Pressure of <90 or >170 Diastolic Blood Pressure of <50 or >100 Temperature of <96 degrees of >100.5 degrees." Patient #6's record included PT visits on 2/03/20, 2/05/20, 2/10/20, 2/12/20, and 2/17/20. Patient #6's record included ST visits on 2/04/20, 2/06/20, and 2/11/20. There were no vital signs documented in Patient #6's medical record for the 8 therapy visits between 2/03/20 and 2/17/20. The Clinical Manager was interviewed on 2/19/20 at 4:15 PM. She confirmed with the 2/03/20 physician order that staff should be taking Patient #6's vital signs. She confirmed there were no vital signs documented in Patient #6's medical	{G 572}		

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{G 572}	Continued From page 7 record. Patient #6's vital signs were not taken as ordered on the POC.	{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 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 observation, record review, review of a	{G 574}		

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{G 574}	Continued From page 8 chart audit tool, patient interview, and staff interview, it was determined the agency failed to ensure POCs were individualized and inclusive of required content for 3 of 10 patients (#2, #7, and #8) whose home health records were reviewed. This resulted in incomplete POCs that did not address all the individualized needs of patients. Findings include: 1. Patient #2 was a 71 year old female admitted to the agency on 1/23/20, with a primary diagnosis of aftercare following joint replacement surgery. An additional diagnosis included HTN. She received SN and PT services. Her record, including the POC, for the certification period 1/23/20 to 3/22/20, was reviewed. a. Patient #2's POC included the medication order, "Tramadol 50 mg every 6 hours as needed for pain, effective 1/24/20." Her medical record also included an SN visit note, dated 2/05/20, signed by the LPN. The LPN documented, "Pt reporting she was told she can use 2 Tramadol [100 mg] instead of 1 [50 mg] at a time ... We [the agency] have faxed PCP for med clarifications and will look for updated orders reviewed by PCP." Patient #2's POC did not include her new Tramadol dosage. b. An RN visit was observed in Patient #2's home on 2/19/20, beginning at 10:00 AM. During the home visit, Patient #2's medications were compared to her POC and 5 inaccuracies were identified: - Glucosamine Chondroitin 500-400 mg, 2 caps daily, was listed on her POC. Patient #2 stated she took Glucosamine Chondroitin 1500-1200 mg once per day.	{G 574}		

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{G 574}	Continued From page 9 - Sennosides/docusate sodium 806-50 mg daily, was listed on her POC. Patient #2 stated she took docusate 100 mg, 1-2 at night. - Patient #2 stated she took melatonin 10 mg before bedtime. Melatonin 10 mg at bed time, was not listed on her POC. - Milk thistle 150 mg, 2 caps daily, was listed on her POC. Patient #2 stated she took milk thistle 200 mg, 2 caps daily. - Omega 3 fatty acids/fish oil 340-100 mg daily, was listed on her POC. Patient #2 stated she took omega 3 fatty acids 300 mg, 2 caps daily. The Clinical Director was interviewed on 2/19/20, beginning at 4:50 PM, and Patient #2's medical record was reviewed in her presence. She confirmed Patient #2's POC was not accurate and did not include all medications she was currently taking. Patient #2's POC was not complete to include all medications she was currently taking. 2. Patient #8 was a 71 year old female admitted to the agency on 2/05/20, with a primary diagnosis of malignant neoplasm of lung. Additional diagnoses included secondary malignant neoplasm of brain and COPD. She received SN and Aide services. Her record, including the POC, for the certification period 2/05/20 to 4/04/20, was reviewed. Patient #8's record included an SN visit note, dated 2/12/20, signed by the RN. The RN documented, "she [Patient #8] is starting to feel	{G 574}		

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{G 574}	Continued From page 10 constipated now so they picked up OTC glycerine [sic] suppositories, physician phoned to request order for this medication." Patient #8's POC did not include an order for glycerin suppositories. The Clinical Manager was interviewed on 2/19/20, beginning at 3:57 PM, and Patient #8's medical record was reviewed in her presence. She confirmed Patient #8's POC did not include her glycerine suppositories. Patient #8's POC did not include all of her medications. 3. Patient #7 was a 91 year old male admitted to the agency on 2/04/20, with a primary diagnosis of pneumonia. An additional diagnosis included chronic pain. He received PT and OT services. His record, including the POC, for the certification period 2/04/20 to 4/03/20, was reviewed. a. Patient #7's record included an SOC OASIS, dated 2/05/20, signed by the Physical Therapist. Pneumonia was listed as Patient #7's primary diagnosis with a severity code of 3, meaning his symptoms were poorly controlled and needed frequent adjustments in treatment and monitoring. Pain in the left knee was listed as a secondary diagnosis with a severity code of 2 (meant Patient #7's symptoms were controlled with difficulty and he needed ongoing monitoring). Patient #7's POC did not include interventions, outcomes, or goals related to his pneumonia and left knee pain. The Clinical Manager was interviewed on 2/19/20 at 5:00 PM. When asked if there were interventions, outcomes, or goals related to pneumonia and left knee pain in Patient #7's	{G 574}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 574}	Continued From page 11 POC, she confirmed there were not. Patient #7's POC did not include interventions, outcomes, or goals related to all pertinent diagnoses. b. The HHA implemented a Plan of Correction for citations from a validation survey conducted on 12/16/19. The Plan of Correction stated, "The Clinical Manager or designee will audit 100% of admissions...to ensure that individualized plans of care are created and followed." This Plan of Correction was not followed. A chart audit document was provided for Patient #7, dated 2/05/20. The audit document included a list of possible interventions to ensure the care plan was complete, with options of "Yes," "No," or "N/A [not applicable]." i. The section titled "Pneumonia Protocol" was marked, "N/A," however, Patient #7's primary diagnosis was pneumonia. ii. The section titled "Pain Parameters/Pharm[pharmacological]/Non-Pharm, " was marked "No," however, Patient #7's secondary diagnosis was left knee pain. The Clinical Manager was interviewed on 2/20/20 at 9:30 AM. She confirmed Patient #7's chart audit did not capture missing interventions for pneumonia and left knee pain. A chart audit for Patient #7 did not capture missing interventions for all pertinent diagnoses. c. Patient #7's record included an OT visit note, dated 2/17/20, signed by the Occupational	{G 574}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137107	A. BUILDING _____ B. WING _____	R 02/20/2020

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{G 574}	Continued From page 12 Therapist. The note contained a narrative which stated, "[Patient #7] Stated he was put on prednisone last week and i [sic] did not document this change." Patient #7's medication list, printed on 2/18/19, did not contain prednisone. The Occupational Therapist was interviewed by phone on 2/19/20 at 4:38 PM. When asked if he added prednisone to Patient #7's medication list, he confirmed he did not. He stated it was in a communication note and, "I assume it [the communication note] gets looked at." The Clinical Manager was interviewed on 2/19/20 at 5:00 PM. When asked what should be done when a new medication was identified, she said clinicians were to add the medication to the medication list or notify an RN to add it to the medication list. She confirmed the Occupational Therapist identified prednisone in a communication note but stated, "it doesn't communicate anything." Patient #7's medication list did not include all medications he was taking.	{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 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	{G 590}		

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{G 590}	Continued From page 13 ensure physicians were promptly alerted to changes in patients' conditions or needs that suggested a need to alter the POC for 1 of 10 patients (Patient #1) whose records were reviewed. This had the potential for unaddressed patient conditions or needs. Findings include: Patient #1 was an 88 year old female admitted to the agency on 2/01/20, with a primary diagnosis of acute bronchitis. Additional diagnoses included respiratory failure and hypertension. She received SN, PT, and ST services. Her record, including the POC, for the certification period 2/01/20 to 3/31/20, was reviewed. Patient #1's record included a PT visit note, dated 2/06/20, signed by the PTA. The note stated, "CG [caregiver] reports dime size pneumonia on L [left] lung, antibiotic ordered but pt has not started yet, will recheck on next visit to update records." There was no documentation of communication with a physician in Patient #1's medical record to clarify orders or confirm a pneumonia diagnosis. Additionally, there was no antibiotic added to Patient #1's POC after the 2/06/20 PT visit. The Clinical Manager was interviewed on 2/19/20 at 4:15 PM. She confirmed there was no communication with Patient #1's physician regarding a pneumonia diagnosis. She stated there should have been further clarification with Patient #1's physician to confirm if Patient #1 had pneumonia and if she needed antibiotics. Patient #1's physician was not alerted to clarify her new diagnosis and possible need for antibiotics, suggesting a need to alter the POC.	{G 590}		

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{G 608}	Continued From page 14	{G 608}		
{G 608}	Coordinate care delivery CFR(s): 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. This ELEMENT is not met as evidenced by: Based on observation, record review, review of a chart audit, staff interview, and patient interview, it was determined the agency failed to ensure coordination of patient care between the HHA and ALF for 1 of 2 patients (Patient #7) who lived in an ALF and whose records were reviewed. This had the potential to result in missing services and unmet patient needs. Findings include: Patient #7 was a 91 year old male admitted to the agency on 2/04/20, with a primary diagnosis of pneumonia. An additional diagnosis included chronic pain. He received PT and OT services. His record, including the POC, for the certification period 2/04/20 to 4/03/20, was reviewed. The HHA implemented a Plan of Correction for citations from a validation survey conducted on 12/16/19. The Plan of Correction stated, "The Clinical Manager or designee will audit 100% of admissions...to ensure that individualized plans of care are created and followed." This Plan of Correction was not followed. A chart audit document was provided for Patient #7, dated 2/05/20. The audit document included a section titled "Medication Reconciliation" to ensure medications were accurately reconciled. A section stated, "Med [medication] Review of ALF MAR[medication administration record]-discrepancies communication to ALF,"	{G 608}		

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{G 608}	Continued From page 15 with the options of "Yes," "No," or "N/A." This section was left blank. An OT visit provided to Patient #7 at an ALF was observed on 2/19/20, at 8:26 AM. Patient #7's current medication list was reviewed in his presence after the visit was completed. His HHA medication list was compared with the medication list obtained from the ALF. The following discrepancies were identified: 1. Patient #7's ALF medication list stated gabapentin was discontinued on 2/05/20. Patient #7 confirmed he was no longer taking gabapentin. His HHA medication list included gabapentin, 100 mg 3 times a day, as a current medication. 2. Patient #7's ALF medication list included omeprazole 20 mg once daily, started on 2/04/20. Patient #7 confirmed he was taking omeprazole. Omeprazole was not on Patient #7's HHA medication list. 3. Patient #7's ALF medication list included prednisone 20 mg 3 tabs a day at breakfast for 5 days, starting on 2/05/20 and ending on 2/19/20. Patient #7 confirmed he was on his last day of prednisone. Prednisone was not on Patient #7's HHA medication list. The Clinical Manager was interviewed on 2/19/20 at 5:05 PM. She confirmed gabapentin was on the HHA medication list as a current medication. The Clinical Manager confirmed omeprazole was not on the HHA medication list. She confirmed prednisone was not added to the HHA medication list until after it was identified by the surveyor on 2/19/20. The Clinical Manager confirmed the	{G 608}		

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{G 608}	Continued From page 16 gabapentin, omeprazole, and prednisone were not accurately identified on the HHA medication list. She confirmed the chart audit did not identify all medication discrepancies. Patient #7's care was not coordinated with his ALF to ensure all medications were included on his POC.	{G 608}		

RECEIVED
MAR 1 1 2020
FACILITY STANDARDS

G 570 Care planning, coordination, quality of care CFR(s) 484.60

What action will be taken to correct the deficiency cited?
On or before 03/18/2020 all clinical staff, therapy staff, and contracted providers will be educated by the Clinical Manager and or designee that patients must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training.

Who is responsible to implement the corrective action?
Clinical Manager and or designee

What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action plan?

Refer to G572

Refer to G574

Refer to G590

Refer to G608

The Administrator will ensure that if 100% compliance is not achieved re-education will be completed. Also, that a performance improvement project will be implemented and monitored. The Quality Improvement coordinator or designee will present the findings monthly to QAPI committee. The QAPI committee will report results to the Governing Body quarterly. Once compliance is achieved 10% of the agency census will have a chart review completed quarterly ongoing.

When will the corrective action be implemented? 03/18/2020

G 572 Plan of care must include the following CFR(s) 484.60(a)(1)

What action will be taken to correct the deficiency cited?
On or before 03/18/2020 all clinical staff, therapy staff, and contracted providers will be educated by the Clinical Manager and or designee that an individualized plan of care that identifies patient-specific measurable outcomes and goals, is established, and periodically reviewed, and signed by a doctor.

Also, education provided about how to properly document all aspects of the plan of care, including but not limited to:

- Patients' must receive aide visits as ordered on the POC
- Patients' physicians must be notified of low oxygen saturation
- Patients' weights must be monitored per the plan of care
- Patients' vital signs must be monitored per the plan of care
- Patients' canceled/missed visits must be communicated to physicians for disciplines ordered on the POC
- Patients' physicians must be notified of a weight loss per the plan of care
- Patients' BG levels must be addressed and documented as ordered on the POC
- Patient's lab results must be completed as ordered on the POC

Who is responsible to implement the corrective action?
Clinical Manager and or designee

What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action plan?
The Clinical Manager or designees will audit 15 patients charts weekly. Auditing routine/non-OASIS visits to ensure that the plan of care and physician orders are being established and followed. Also ensuring that physicians are being notified to approve changes updates, or modifications to the plan of care. 3 times weekly the missed visit report will be reviewed by the Clinical Manager or designee to ensure physicians have been notified of missed visits. Monitoring will continue until 100% compliance is maintained for 3 months.

Then the Clinical Manager or designee will audit 7 patient charts weekly. Auditing routine and non-OASIS visits to ensure that the plan of care and physician orders are being established and followed. Also, ensuring that physicians are being notified to approve changes, updates, or modification to the plan of care. and physicians are being notified. Monitoring will continue until 100% compliance is maintained for 2 months.

Then the Clinical Manager or designee will audit 5 patient charts weekly. Auditing routine and non-OASIS visits to ensure that the plan of care and physician orders are being established and followed. Also, ensuring that physicians are being notified to approve changes, updates, or modifications to the plan of care. Monitoring will continue until 100% compliance is maintained for 1 month.

The Administrator will ensure that if 100% compliance is not achieved re-education will be completed. Also, that a performance improvement project will be implemented and monitored. The Quality Improvement coordinator or designee will present the findings monthly to QAPI committee. The QAPI committee will report results to the Governing Body quarterly. Once compliance is achieved 10% of the agency census will have a chart review completed quarterly ongoing.

When will the corrective action be implemented? 03/18/2020

G 574 Plan of care must include the following CFR(s) 484.60(a)(2)

What action will be taken to correct the deficiency cited?
On or before 03/18/2020 all registered nurses, therapy staff, and contracted providers will be re-educated by the Clinical Manager and or designee that individualized plans of care must include all information outlined in CFR 484.360 (a)(2) T. Also, specific education with demonstration, problem solving techniques, and some return demonstration was provided on how to properly preform medication reconciliation.

Also, education provided about how to properly document all aspects of the plan of care, including but not limited to;

- Patients' POC must include interventions and goals for all pertinent diagnoses
- Patients' POC must include interventions for all pertinent diagnoses
- Patients' POC must include all medications and treatments.
- Patients' POC must include the types of services, supplies, and equipment required
- Patients' POC should not include interventions that are not pertinent to their care
- Patients' POC should reflect an accurate accounting of their allergies
- Patients' POC should include accurate accounting of their nutritional requirements and specific interventions, measurable outcomes, and goals
- Patients' POC should include specific interventions, measurable outcomes, and goals

Who is responsible to implement the corrective action?
Clinical Manager and or designee

What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action plan?
The Clinical Manager or designee will audit 100% of admissions and recertification records and comprehensive assessments to ensure that individualized plans of care are created and followed. 50% of the original audits will be reviewed again to ensure accuracy. 5 in home medication reconciliation reviews will occur weekly. Monitoring will continue until 100% compliance is maintained for 3 months.

Then the Clinical Manager or designee will audit 75% of admission and recertification records and comprehensive assessments to ensure that individualized plans of care are created and followed. 3 in home medication reconciliation reviews will occur weekly. Monitoring will continue until 100% compliance is maintained for 2 months.

Then the Clinical Manager or designee will audit 50% of admission and recertification records and comprehensive assessments to ensure that individualized plans of care are created and followed. 1 medication reconciliation review will occur weekly. Monitoring will continue until 100% compliance is maintained for 1 month.

The Administrator will ensure that if 100% compliance is not achieved re-education will be completed. Also, that a performance improvement project will be implemented and monitored. The Quality Improvement coordinator or designee will present the findings monthly to QAPI committee. The QAPI committee will report results to the Governing Body quarterly. Once compliance is achieved 10% of the agency census will have a chart review completed quarterly ongoing.

When will the corrective action be implemented? 03/18/2020

G 590 Promptly alert relevant physician of changes CFR(s) 484.60(C)(1)

What action will be taken to correct the deficiency cited?
On or before 03/18/2020 all clinical staff, therapy staff, and contracted providers will be educated by the Clinical Manager and or designee that relevant physicians should be promptly alerted 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. Also, specific education and case studies were reviewed that would demonstrate to staff changes in condition that should be communicated to the physician. One on One education will occur on or before 3/18/2020 with the identified staff who failed to alert and clarify a possible new diagnosis and need for new medications with the physician.

Also discussing scenarios and events when

- Communication with the physician on the patient's DMII status is uncontrolled
- Communication with the physician patients reported/caregiver changes of condition

Who is responsible to implement the corrective action?
Clinical Manager and or designee

What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action plan?
The Clinical Manager or designee will audit 15 patients charts weekly. Routine/non-OASIS visits will be reviewed to ensure that patients are being monitored for a change in condition and physicians are being notified when appropriate. 50% of all visit notes will be reviewed by Clinical Manager and designees weekly for 30 days. Clinicians who have less than 20% of their notes returned will be removed from the audit. Clinicians with a return rate greater than 20% of their notes returned will be placed on a performance improvement plan. Monitoring will continue until 100% compliance is maintained for 3 months.

Then the Clinical Manager or designee will audit 7 patient charts weekly. Routine/non-OASIS visits will be reviewed to ensure that patients are being monitored for a change of condition and physicians are being notified when appropriate. Monitoring will continue until 100% compliance is maintained for 2 months.

Then the Clinical Manager or designee will audit 5 patients charts weekly. Routine/non-Oasis visits will be reviewed to ensure that patients are being monitored for a change of condition and physicians are being notified when appropriate. Monitoring will continue until 100% compliance is maintained for 1 month.

The Administrator will ensure that if 100% compliance is not achieved re-education will be completed. Also, that a performance improvement project will be implemented and monitored. The Quality Improvement coordinator or designee will present the findings monthly to QAPI committee. The QAPI committee will report results to the Governing Body quarterly. Once compliance is achieved 10% of the agency census will have a chart review completed quarterly ongoing.

When will the corrective action be implemented? 03/18/2020

G 608 Coordinate care delivery CFR(s) 484.60(d)(4)

What action will be taken to correct the deficiency cited?
On or before 03/18/2020 all clinical staff, therapy staff, and contracted providers will be educated by the Clinical Manager and or designee when to coordinate care delivery to meet the patient's needs, and involve the patient representative, and caregiver(s), as appropriate, in the coordination of care activities. Also, specific education with demonstration, problem solving techniques, and some return demonstration was provided on how to properly preform medication reconciliation.

Discussion scenarios when;

- Patients' medication reconciliation and administration with the Assisted Living Facility staff
- How and when to communicate medication changes to the physician and Assisted Living Staff.

Who is responsible to implement the corrective action?
Clinical Manager and or designee

What is the monitoring process we will put into place to implementation and effectiveness of the corrective action plan?
The Clinical Manager or designee will audit 15 patients charts weekly. Auditing routine/non-OASIS visits to ensure that coordination of care is occurring with patient representative and caregivers as appropriate. 5 in home/ALF medication reconciliations reviews will occur weekly. Medication Records will be requested weekly for ALF patients to ensure accurate reconciliation occurs. Monitoring will continue until 100% compliance is maintained for 3 months.

Then the Clinical Manager or designee will audit 7 patients charts weekly. Auditing routine/non-OASIS visits to ensure that coordination of care is occurring with patient representative and caregivers as appropriate. 3 in home medication reconciliations reviews will occur weekly. Monitoring will continue until 100% compliance is maintained for 2 months.

Then the Clinical Manager or designee will audit 5 patients charts weekly. Auditing routine/non-OASIS visits to ensure that coordination of care is occurring with patient representative and caregivers as appropriate. 1 in home medication reconciliations reviews will occur weekly. Monitoring will continue until 100% compliance is maintained for 1 month.

The Administrator will ensure that if 100% compliance is not achieved re-education will be completed. Also, that a performance improvement project will be implemented and monitored. The Quality Improvement coordinator or designee will present the findings monthly to QAPI committee. The QAPI committee will report results to the Governing Body quarterly. Once compliance is achieved 10% of the agency census will have a chart review completed quarterly ongoing.

When will the corrective action be implemented? 03/18/2020