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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

April 23, 2019

Amy Mansfield, Administrator
Encompass Health Home Health Of Eastern Idaho
3686 Washington Parkway
Idaho Falls, ID 83404

RE: Encompass Health Home Health Of Eastern Idaho, Provider #137105

Dear Ms. Mansfield:

On April 18, 2019, an on-site follow-up revisit was conducted to verify that Encompass Health Home Health Of Eastern Idaho was in compliance with all Conditions of Participation. The agency's allegation of compliance indicated your agency was in substantial compliance as of April 12, 2019. However, based on our on-site revisit conducted April 18, 2019, your agency remains out of compliance with the following Condition of Participation:

- **Care planning, coordination of services, and 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 Encompass Health Home Health Of Eastern Idaho 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 forms.**

Please complete your Allegation of Compliance/Plan of Correction and submit it to this office by **May 3, 2019**. 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 **May 10, 2019**. 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 March 8, 2019 recertification survey of your agency:

Termination [42 CFR 488.865]

You were notified of this recommendation in our March 21, 2019 letter, sent following the March 8, 2019, recertification 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-BC, Supervisor
Non-Long Term Care

DK/dk
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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137105	A. BUILDING _____ B. WING _____	R 04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCOMPASS HEALTH HOME HEALTH OF EASTERN IDAHO	3686 WASHINGTON PARKWAY IDAHO FALLS, ID 83404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 000}	INITIAL COMMENTS	{G 000}		

The following deficiencies were cited during the Medicare follow-up survey of your agency conducted on 4/18/19. Surveyors conducting the follow-up survey were:

Nancy Bax, RN, BSN, HFS, Team Lead
Teresa Hamblin, RN, MS, HFS
Brian Osborn, RN, HFS

Acronyms used in this report include:

ASHD - Arteriosclerotic Heart Disease
BG - Blood Glucose
BID - Two times per day
COG - Cognitive
COPD - Chronic Obstructive Pulmonary Disease
DM - Diabetes Mellitus
DME - Durable Medical Equipment
GERD - Gastroesophageal Reflux Disease
HFS - Health Facility Surveyor
HTN - Hypertension
IU - International Units
LPN - Licensed Practical Nurse
MAHC - Missouri Alliance for Home Care
mg - Milligram
mg/dl - Milligram per Deciliter
MSW - Medical Social Worker
OT - Occupational Therapy
POC - Plan of Care
PT - Physical Therapy
RN - Registered Nurse
RNCM - Registered Nurse Case Manager
SOC - Start of Care
SN - Skilled Nursing
SQ - Subcutaneous
ST - Speech Therapy
TIA - Transient Ischemic Attack

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APR 26 2019
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Mansfield RN	Regional Administrator	4/26/19

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 000}	Continued From page 1 TID - Three times per day TKA - Total Knee Arthroplasty UTI - Urinary Tract Infection VA - Veterans Affairs	{G 000}		
{G 570}	Care planning, coordination, quality of care 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, agency policy review, and staff, and patient interview, it was determined the agency failed to ensure care and treatments followed the patients' POCs, POCs were accurate and included all pertinent items, verbal orders were written and authenticated by the physician, physicians were alerted to changes in patient condition, and care was coordinated between disciplines. These failures had the potential to result in unmet	{G 570}		

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{G 570}	Continued From page 2 patient needs and negatively impact the continuity, safety, and quality of patient care. Findings include: 1. Refer to G572 as it relates to the agency's failure to ensure care followed patients' written POCs. 2. Refer to G574 as it relates to the agency's failure to ensure patients' POCs were accurate and included all pertinent items. 3. Refer to G580 as it relates to the agency's failure to ensure treatments were administered only as ordered by the physician. 4. Refer to G584 as it relates to the failure of the agency to ensure verbal orders were put in writing and signed by patients' physicians. 5. Refer to G590 as it relates to the agency's failure to ensure staff promptly alerted the physician to changes in patients' conditions or needs. 6. Refer to G606 as it relates to the agency's failure to ensure coordination of patient care between disciplines. 7. Refer to G608 as it relates to the agency's failure to ensure care was coordinated to meet the patients' needs. The cumulative effect of these negative systemic practices impeded the agency's ability to provide quality care in accordance with established POCs.	{G 570}		
{G 572}	Plan of care	{G 572}		

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{G 572}	Continued From page 3 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 record 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 1 of 9 patients (Patient #6) whose records were reviewed. This had the potential to interfere with quality and safety of patient care. Findings include: Patient #6 was an 86 year old female admitted to the agency on 9/13/17, with diagnoses that included DM Type 2, insulin dependence, oxygen dependence, and a history of UTIs and a TIA. She received SN services. Her record was reviewed, including the POC, for the certification period beginning 3/07/19 and the clinical record contents between 4/12/19 through 4/18/19. Patient #6's POC was not followed. Examples include: 1. Patient #6's POC included out-of-range reporting parameters for vital signs. The RN visit note, dated 4/13/19, did not include	{G 572}		

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{G 572}	Continued From page 4 documentation that Patient #6's vital signs were assessed. 2. Patient #6's POC indicated Patient #6 was prescribed oxygen at 2 liters via nasal cannula at bedtime, and SN was to assess her for respiratory complications. It also included the expectation "SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS...AND INTERVENE TO MINIMIZE COMPLICATIONS." An RNCM visit note, dated 4/18/19, documented Patient #6's respiratory assessment, including "ABNORMAL BREATH SOUNDS," "VERY SLIGHT BREATHLESSNESS," "WHEEZES" in the "RIGHT UPPER LOBE," "RIGHT LOWER LOBE," "LEFT UPPER LOBE" RIGHT MIDDLE LOBE," "LEFT LOWER LOBE." It documented Patient #6 was "ON ROOM AIR" and "...FAILURE TO WEAR O2." There was no documentation of interventions, such as relevant patient education or coordination with the physician to intervene and minimize complications. 3. Patient #6's POC stated "SKILLED NURSE TO ASSESS SKIN INTEGRITY..." An RN visit note, dated 4/15/19, documented an abrasion to Patient #6's right knee secondary to a fall. Similarly, an RNCM visit note, dated 4/18/19, documented "STABLE SCABS PRESENT TO BOTH KNEES." This documentation was inconsistent with 2 LPN visit notes, dated 4/16/19 and 4/17/19, which documented "YES" in response to the question "DOES THE CLIENT HAVE INTACT SKIN TO THE LOWER EXTREMITIES?"	{G 572}		

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{G 572}	Continued From page 5 The SN visits on 4/16/19 and 4/17/19 did not accurately assess skin integrity, as the abrasion or scabs were not referenced. The Regional Administrator was interviewed on 4/18/19 at 4:30 PM. She reviewed Patient #6's record and state vital signs should have been assessed during the nursing visit on 4/13/19. She confirmed Patient #6 did not receive education or coordination of care related to her worsening respiratory symptoms. She also confirmed the LPN visits on 4/16/19 and 4/17/19 did not accurately document a skin assessment. Patient #6's POC was not followed as it related to a failure to assess vital signs, a failure to intervene to minimize complications of worsening respiratory symptoms, and a failure to conduct skin assessment.	{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;	{G 574}		

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{G 574}	Continued From page 6 (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, medical record review, and patient and staff interview, it was determined the agency failed to ensure POCs were individualized and inclusive of required content for 7 of 9 patients (#1, #2, #3, #4, #6, #7, and #9) whose records were reviewed. This resulted in incomplete POCs that did not address all of the individualized needs of patients. Findings include: 1. Patient #9 was a 66 year old female admitted to the agency on 3/19/19, with a primary diagnosis of prediabetes. Additional diagnoses included lumbago with sciatica, metabolic encephalopathy, repeated falls, and anxiety disorder. Her POC for the certification period 3/19/19 to 5/17/19, and medical record content from 4/12/19 to 4/18/19, were reviewed. A visit was made to Patient #9's home on 4/18/19 at 3:00 PM, to observe an SN visit completed by the RNCM. During the visit, Patient #9's medications and supplies were reviewed and compared to her current POC and medication list. Variances were noted, as follows:	{G 574}		

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{G 574}	Continued From page 7 a. Patient #9's POC and medication list included Lamotrigine 200 mg daily for bipolar disorder. A medication bottle in Patient #9's home included Lamotrigine 25 mg tablets. Patient #9 stated she took 25 mg, 1 tab daily. b. Patient #9's POC and medication list included Aripiprazole 10 mg, 0.5 tab daily at bedtime for bipolar disorder. A medication bottle in Patient #9's home included Aripiprazole 10 mg, with label instructions to take 1 tab daily at bedtime. Patient #9 stated the dose was increased to 1 tab in February 2019. c. Patient #9's POC and medication list included Atenolol 100 mg 2 times a day for blood pressure. A medication bottle in Patient #9's home included Atenolol 25 mg tablets, with label instructions to take 2 times a day. d. Patient #9's POC and medication list included Gabapentin 900 mg, 1 tab daily for nerve pain. A medication bottle in Patient #9's home included Gabapentin 300 mg tablets, with label instructions to take 3 tablets 3 times a day, for a total of 900 mg 3 times a day. Patient #9 confirmed she was currently taking the following medications that were in her home, but not included on her current POC or medication list: e. Hydroxaxine 25 mg with label instructions to take 4 times a day as needed for anxiety and/or itching. Patient #9 stated she was taking 1 tab 3 times a day on a regular basis. f. Ferrous Sulfate (iron) 325 mg 2 times a day.	{G 574}		

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{G 574}	Continued From page 8 Patient #9 stated she was taking 1 tab daily and did not realize the instructions stated 2 times a day. g. Vitamin A 10,000 IU daily h. Vitamin D3 5000 IU daily i. Vitamin E 134.2 mg daily j. CoQ10 120 mg daily k. Multivitamin daily l. Vitamin B Complex 3 times a day m. Potassium 99 mg daily n. Acyclovir 800 mg 3 times a day, taken as needed for cold sores o. Tums, taken as needed for heartburn p. Patient #9 stated she tested her BG every day with a glucometer. Her POC did not include the glucometer, test strips, or lancets used to test her BG. During an interview on 4/18/19 at 6:10 PM, the Regional Administrator reviewed Patient #9's POC and medication list, and confirmed they did not include an accurate list of the medications she was taking or the supplies used to test her BG. The agency failed to ensure Patient #9's POC and medication list included an accurate list of medications and supplies she was taking.	{G 574}		

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{G 574}	Continued From page 9 2. Patient #1 was an 81 year old male admitted to the agency on 4/11/19, for care following a left TKA. Additional diagnoses included ASHD and HTN. He received SN and PT services. His record, including the POC, for the certification period 4/11/19 to 6/09/19, and record content between 4/12/19 and 4/18/19, was reviewed. a. Patient #1's record included an SN visit note, dated 4/12/19, signed by an LPN. The note stated, "REMOVED PAIN BALL AS ORDERED." Pain balls are pain relief devices used after orthopedic surgery, to provide pain relief by administering numbing medication through a small catheter inserted into the femoral nerve. Patient #1's POC did not include his pain ball. It could not be determined what medication was administered by the pain ball, or the medication dose and frequency. b. Patient #1's POC included the diagnosis "DEPENDENCE ON SUPPLEMENTAL OXYGEN." His POC did not include precautions related to oxygen use, such as posting of signs in his home to alert to oxygen use, or warnings related to smoking or open flames in his home. During an interview on 4/18/19 at 5:30 PM, the Regional Administrator reviewed Patient #1's record and confirmed his POC did not include his pain ball, or the medication administered by the pain ball. Additionally she confirmed Patient #1's POC did not include precautions related to his oxygen use. Patient #1's current POC was not comprehensive to include his pain relief ball, pain medication, or oxygen precautions.	{G 574}		

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{G 574}	Continued From page 10 3. Patient #6 was an 86 year old female admitted to the agency on 9/13/17, with diagnoses that included DM Type 2, insulin dependence, oxygen dependence, and a history of UTIs and a TIA. She received SN services. Her record was reviewed, including the POC, for the certification period beginning 3/07/19 and the clinical record contents from 4/12/19 through 4/18/19. a. Patient #6's POC indicated she was on oxygen at 2 liters via nasal cannula and that SN was to assess for respiratory complications. The POC did not include respiratory goals or oxygen supplies or equipment. b. Patient #6's POC include DME and Supplies: "WOUND CARE....COMPRESSION." There was no documentation of wounds. c. Patient #6's POC indicated she was prescribed 3 medications for glaucoma, including "BRIMONIDINE OPHTHALMIC," "DORZOLAMIDE-TIMOLOL OPHTHALMIC," and "TRAVARTAN Z OPHTHALMIC." Glaucoma was not listed as a diagnosis on the POC. d. Patient #6's POC indicated she was prescribed "OMEPRAZOLE ORAL" for GERD. This diagnosis was not included on Patient #6's POC. The Regional Administrator was interviewed on 4/18/19 at 4:30 PM. She reviewed the record and confirmed Patient #6's POC did not include respiratory goals or oxygen equipment. She also stated she did not see evidence of a wound and was not sure why the POC included DME and supplies for wound care. She agreed that the diagnoses of glaucoma and GERD should have	{G 574}		

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{G 574}	Continued From page 11 been included on Patient #6's POC. Patient #6's POC was not individualized to include respiratory goals, known diagnoses, and relevant DME/supplies. 4. Patient #7 was a 61 year old female admitted to the agency on 6/19/18, with diagnoses that included surgical aftercare, repeated falls, scoliosis, generalized muscle weakness, bipolar disorder, anxiety disorder, chronic pain syndrome, osteoporosis, Crohn's disease, anemia, and insomnia. She received SN and MSW services. Her record was reviewed, including the POCs for certification periods ending 4/14/19 and beginning 4/15/19, and record contents between 4/12/19 and 4/18/19. a. Patient #7's POC, dated 4/15/19, documented she was prescribed "AMLODIPINE ORAL" for hypertension, "GABAPENTIN ORAL" for neuropathy, "OMEPRAZOLE ORAL" for GERD, and "TOVIAZ ORAL" for incontinence. These diagnoses were not included on Patient #7's POC." b. Patient #7's POC, dated 4/15/19, included orders for "DIABETIC FOOT CARE." Patient #7 did not have diabetes. The plan was not individualized to reflect relevant interventions. The Regional Administrator was interviewed on 4/18/19 at 5:00 PM. She reviewed Patient #7's record and confirmed known diagnoses were not included on the POC. She also confirmed that Patient #7 did not have a diagnosis of diabetes and therefore diabetic foot care was not relevant. Patient #7's POC was not individualized to	{G 574}		

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	137105	A. BUILDING _____ B. WING _____	R 04/18/2019

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{G 574}	Continued From page 12 include known diagnoses. It included information that was not relevant to Patient #7. 5. Patient #4 was a 78 year old male admitted to the agency on 4/11/19, with a primary diagnosis of left foot ulcer. Additional diagnoses included pain and DM. He received SN and MSW services. His POC, for the certification period 4/11/19 to 6/09/19, and medical record content from 4/12/19 to 4/18/19, were reviewed. a. Patient #4's medical record included an SN visit note, dated 4/17/19, signed by the LPN, which stated "PT [patient] HAS INSULIN PUMP." The insulin pump was not included on Patient #4's POC. The Regional Administrator was interviewed on 4/18/19, beginning at 3:47 PM, and Patient #4's medical record was reviewed in her presence. She confirmed Patient #4's POC did not include all of his DME. Patient #4's POC did not include all required equipment. b. Patient #4's medical record included a "Client Medication Report," reviewed 4/14/19, signed by the RNCM, which listed the following medications for pain relief: - Hydrocodone 5-325 mg 1 tab 3 times daily as needed for pain. - Tylenol 500 mg 2 tabs every 6 hours as needed for pain. Patient #4's medical record included an SN visit note, dated 4/17/19, signed by an LPN, which	{G 574}		

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{G 574}	Continued From page 13 included a pain assessment ranked 0 to 10, with 10 being the most severe pain: - "CURRENT RATING OF PAIN...7" - "PAIN RATING AT ITS BEST OVER LAST 24 HOURS...7" - "PAIN RATING AT ITS WORST OVER LAST 24 HOURS...9" Patient #4's POC did not include individualized goals and interventions for his pain. The Regional Administrator was interviewed on 4/18/19, beginning at 3:47 PM, and Patient #4's medical record was reviewed in her presence. She confirmed Patient #4's POC did not include individualized goals and interventions for his pain. Goals and interventions related to pain were not present on Patient #4's POC. c. Patient #4's medical record included an SN visit note, dated 4/17/19, signed by an LPN, which stated: The American Diabetes Association website, accessed 4/22/19, stated: "The American Diabetes Association suggests the following targets for most nonpregnant adults with diabetes..." - "Before a meal (preprandial plasma glucose): 80 - 130 mg/dl" - "1 - 2 hours after beginning of the meal (Postprandial plasma glucose): Less than 180	{G 574}		

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{G 574}	Continued From page 14 mg/dl" - "ENDOCRINE/HEMATOPOIETIC ASSESSMENT...DIABETES MELLITUS" - "OVER THE LAST TWO WEEKS WHAT WAS THE PATIENT'S ACTUAL BLOOD SUGAR RANGE (LOW TO HIGH)?...200 - 500 [mg/dl]" - "Random Blood Sugar...483 [mg/dl]" - "PT HAS INSULIN PUMP" Patient #4's POC did not include individualized goals and interventions for his DM. Additionally, Patient #4's POC did not include paramaters for reporting out-of-range BG values to the physician. The Regional Administrator was interviewed on 4/18/19, beginning at 3:47 PM, and Patient #4's medical record was reviewed in her presence. She confirmed Patient #4's POC did not include individualized goals and interventions for his DM, and did not include blood glucose physician reporting parameters. Goals and interventions related to DM were not individualized on Patient #4's POC. 6. Patient #2 was an 81 year old male admitted to the agency on 4/12/19, with a primary diagnosis of atrial fibrillation. Additional diagnoses included COPD, HTN, and falls. He received SN, PT, OT, and ST services. His POC, for the certification period 4/12/19 to 6/10/19, and medical record from 4/12/19 to 4/18/19, were reviewed. a. Patient #2's medical record included an SN	{G 574}		

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{G 574}	Continued From page 15 SOC comprehensive assessment, dated 4/12/19, signed by his RNCM, which stated "EQUIPMENT CURRENTLY IN USE BY PATIENT...CANE...WALKER..." These 2 DME were not included on Patient #2's POC. The Regional Administrator was interviewed on 4/18/19, beginning at 3:21 PM, and Patient #2's medical record was reviewed in her presence. She confirmed Patient #2's POC did not include all of his DME. Patient #2's POC did not include all required equipment. b. Patient #2's medical record included an SN SOC comprehensive assessment, dated 4/12/19, signed by his RNCM, which stated "ACCORDING TO THE MAHC 10 FALL RISK ASSESSMENT, THIS PATIENT'S SCORE IS: 10" and "BASED ON THE SCORE, THE PATIENT IS: AT RISK FOR FALLING." Patient #2's POC did not include individualized goals and interventions to help prevent falls. The Regional Administrator was interviewed on 4/18/19, beginning at 3:21 PM, and Patient #2's medical record was reviewed in her presence. She confirmed Patient #2's POC did not include individualized goals and interventions to help prevent falls. Goals and interventions related to falls were not present on Patient #2's POC. 7. Patient #3 was a 69 year old female admitted to the agency on 8/13/18, with a primary diagnosis of joint replacement aftercare. Additional diagnoses included pressure ulcer and	{G 574}		

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{G 574}	Continued From page 16 falls. She received PT services. Her POC, for the certification period 4/10/19 to 6/08/19, and medical record from 4/12/19 to 4/18/19, were reviewed. Patient #3's medical record included a "Client Medication Report," last reviewed 4/08/19, signed by her Physical Therapist, which listed 2 anticoagulants (medications used to thin the blood): - Aspirin 325 mg 1 tablet at bedtime - Xarelto 10 mg 1 tablet daily Patient #3's POC did not include safety measures related to risk of bleeding due to use of anticoagulant medications. The Regional Administrator was interviewed on 4/18/19, beginning at 3:30 PM, and Patient #3's medical record was reviewed in her presence. She confirmed Patient #3's POC did not include anticoagulant safety measures. Patient #2's POC did not include all safety measures to protect her from injury.	{G 574}		
{G 580}	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician. This ELEMENT is not met as evidenced by: Based on observation, agency policy review, medical record review, and staff interview, it was determined the agency failed to ensure treatments were administered only as ordered by the physician for 3 of 9 patients (#1, #7, and #9)	{G 580}		

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{G 580}	Continued From page 17 whose records were reviewed. This resulted in unauthorized treatments, and had the potential to negatively impact the safety and quality of patient care. Findings include: 1. Patient #1 was an 81 year old male admitted to the agency on 4/11/19, for care following a left TKA. Additional diagnoses included ASHD and HTN. He received SN and PT services. His record, including the POC, for the certification period 4/11/19 to 6/09/19, and record content between 4/12/19 and 4/18/19, was reviewed. a. Patient #1's record included an SN visit note, dated 4/12/19, signed by an LPN. The note stated, "REMOVED PAIN BALL AS ORDERED." Pain balls are pain relief devices used after orthopedic surgery, to provide pain relief by administering numbing medication through a small catheter inserted into the femoral nerve. Patient #1's record did not include a physician's order to remove his pain ball. b. Patient #1's POC included an order to leave the surgical dressing to his knee in place for 7 days, then remove his dressing on his 7th post-operative day. His record stated his right TKA was performed on 4/09/19. Patient #1's medical record included an SN visit note, dated 4/12/19, signed by an LPN. The noted stated the LPN changed Patient #1's right knee dressing due to saturation. His record did not include a physician's order to change his knee dressing prior to 4/16/19, 7 days after his surgery. During an interview on 4/18/19 at 5:30 PM, the Regional Administrator reviewed Patient #1's record and confirmed it did not include a	{G 580}		

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{G 580}	Continued From page 18 physician's order to remove his pain ball or to change his knee dressing prior to 4/16/19. Patient #1's pain ball was removed, and the dressing to his knee was changed, without a physician's order. 2. Patient #9 was a 66 year old female admitted to the agency on 3/19/19, with a primary diagnosis of prediabetes. Additional diagnoses included lumbago with sciatica, metabolic encephalopathy, repeated falls, and anxiety disorder. Her POC for the certification period 3/19/19 to 5/17/19, and medical record content from 4/12/19 to 4/18/19, were reviewed. The Mayo Clinic website, accessed 4/22/19, stated, "Diabetes has many possible complications, including nerve damage (neuropathy)... If you have any degree of nerve damage, you may not be able to sense if an electric blanket or heating pad is too hot - which can lead to inadvertent burns." A visit was made to Patient #9's home on 4/18/19 at 3:00 PM, to observe an SN visit completed by the RNCM. a. During the visit, the RNCM advised Patient #9 to use a heating pad to her back for 20 minutes several time a day. Patient #9's POC did not include an order for a heating pad. b. During the visit, Patient #9 asked the RNCM to apply Icy Hot cream, a topical analgesic, to her back, to treat her chronic back pain. The RNCM stated she would help Patient #9 transfer to her bed, then apply the Icy Hot cream. Patient #9's POC did not include an order for Icy Hot cream.	{G 580}		

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{G 580}	Continued From page 19 During an interview on 4/18/19 at 6:10 PM, the Regional Administrator reviewed Patient #9's POC and confirmed it did not include orders for a heating pad or Icy Hot cream. Patient #9's RNCM recommended heat treatment, and applied an analgesic cream without a physician's order. 3. Patient #7 was a 61 year old female admitted to the agency on 6/19/18, with diagnoses that included surgical aftercare, repeated falls, scoliosis, generalized muscle weakness, bipolar disorder, anxiety disorder, chronic pain syndrome, osteoporosis, Crohn's disease, anemia, and insomnia. She received SN and MSW services. Her record was reviewed, including the POCs for certification periods ending 4/14/19 and beginning 4/15/19, and the record contents between 4/12/19 and 4/18/19. Patient #7's POC, dated 4/15/19, stated "SKILLED NURSE TO PERFORM/TEACH WOUND CARE TO LT [left] BREAST BIOPSY SITE..." It did not address wound treatment for a skin tear. An RN visit note, dated 4/17/19, included a section "Interventions Provided." It stated "...SN PERFORMED BASIC 1st AID to SKIN TEAR RT [right] ELBOW." It could not be determined what interventions were included as "basic first aid," for example, whether a topical antibiotic was applied. The Regional Administrator was interviewed on 4/18/19 at 5:00 PM. When asked what was included in basic first aid, she initially responded, "wash it, put on neosporin, and bandaid." She	{G 580}		

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{G 580}	Continued From page 20 then corrected and stated "wash it and put on a bandaid." She also stated "nurses can do basic first aid without an order." Surveyors requested a policy that defined basic first aid. An agency policy, "WOUND/ULCER ASSESSMENT AND MANAGEMENT," revised 3/18/19, was provided for review. The policy included a definition of skin tears under a section described as "Traumatic Wounds." There was no section that addressed "first aid." The policy stated "Wound/ulcer care shall be in accordance with the plan of care." Patient #7's skin tear treatment was not provided as orderd by a physician.	{G 580}		
{G 584}	Verbal orders CFR(s): 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician in accordance with applicable state laws and regulations, as well as the HHA's internal policies. This ELEMENT is not met as evidenced by: Based on medical record review and staff	{G 584}		

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{G 584}	Continued From page 21 interview, it was determined the agency failed to ensure verbal orders were put in writing for 1 of 9 patients (Patient #1) whose records were reviewed. This failure had the potential to negatively impact coordination and clarity of patient care. Findings include: 1. Patient #1 was an 81 year old male admitted to the agency on 4/11/19, for care following a left TKA. Additional diagnoses included ASHD and HTN. He received SN and PT services. His record, including the POC, for the certification period 4/11/19 to 6/09/19, and record content between 4/12/19 and 4/18/19, was reviewed. Patient #1's record included an SN visit note, dated 4/12/19, signed by an LPN. The note stated blood blisters were identified and a dressing was applied to the site, per physician's orders. Patient #1's record included a "Client Coordination Note Report," dated 4/12/19, signed by the LPN. The note stated his physician was contacted regarding the blood blisters and an order was obtained to cover them with absorptive dressing. Patient #1's record did not include a written physician's order for care to his blood blisters. During an interview on 4/18/19 at 5:30 PM, the Regional Administrator reviewed Patient #1's record and stated the LPN contacted the physician regarding his new blood blisters and received an order to provide care. The Regional Administer confirmed the order was not documented in his record, or sent to his physician for signature. 2. Patient #1's record included a "Client Coordination Note Report," dated 4/16/19, signed	{G 584}		

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{G 584}	Continued From page 22 by the Branch Director. The note stated "NEW ORDER RECEIVED FOR WOUND CARE TO RUPTURED BLISTER FOR EVERY OTHER DAY UNTIL RESOLVED." Patient #1's record included a verbal physician's order, dated 4/16/19, signed by the Branch Director. The order stated wound care was to be completed every Monday, Wednesday, and Friday, until resolved. The frequency on the order did not match the frequency on the coordination note. During an interview on 4/18/19 at 5:30 PM, the Regional Administrator reviewed Patient #1's record and confirmed the verbal order for wound care did not match the communication note. The agency failed to ensure verbal orders were documented accurately and authenticated by the physician.	{G 584}		
{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 ensure staff promptly alerted the physician to changes in patients' condition or needs for 2 of 3 diabetic patients (#4 and #6) whose records were reviewed. This failure had the potential to result in the inability of the physician to update the POC to meet the patient's needs. Findings include: Patient #4 was a 78 year old male admitted to the	{G 590}		

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{G 590}	Continued From page 23 agency on 4/11/19, with a primary diagnosis of left foot ulcer. Additional diagnoses included pain and DM. He received SN and MSW services. His POC, for the certification period 4/11/19 to 6/09/19, and medical record from 4/12/19 to 4/18/19, were reviewed. Patient #4's medical record included an SN visit note, dated 4/17/19, signed by an LPN, which stated "Random Blood Sugar...483 [mg/dl]." The LPN did not document if she contacted Patient #4's physician regarding his elevated blood glucose level. The Regional Administrator was interviewed on 4/18/19, beginning at 3:47 PM, and Patient #4's medical record was reviewed in her presence. She confirmed the LPN did not document if she contacted Patient #4's physician regarding his elevated blood glucose level. The physician was not informed of Patient #4's change in condition. 2. Patient #6 was an 86 year old female admitted to the agency on 9/13/17, with diagnoses that included DM Type 2, insulin dependence, oxygen dependence, and a history of UTIs and a TIA. She received SN services. Her record was reviewed, including the POC, for the certification period beginning 3/07/19 and the clinical record from 4/12/19 through 4/18/19. Patient #6's POC indicated she was on oxygen at 2 liters via nasal cannula at bedtime, and SN was to assess for respiratory complications. An RNCM visit note, dated 4/18/19, documented Patient #6's respiratory assessment, including	{G 590}		

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{G 590}	Continued From page 24 "ABNORMAL BREATH SOUNDS," "VERY SLIGHT BREATHLESSNESS," "WHEEZES" in the "RIGHT UPPER LOBE," "RIGHT LOWER LOBE," "LEFT UPPER LOBE," "RIGHT MIDDLE LOBE," and "LEFT LOWER LOBE." It documented she was "ON ROOM AIR" and "... FAILURE TO WEAR O2." There was no documentation the physician was alerted to Patient #6's worsening respiratory status or non-compliance with oxygen usage. The Regional Administrator was interviewed on 4/18/19 at 4:30 PM. She reviewed Patient #6's record and confirmed there was no documentation a physician was notified of Patient #6's respiratory status or oxygen non-compliance. The agency did not promptly alert Patient #6's physician about her worsening respiratory status and noncompliance with oxygen usage.	{G 590}		
{G 606}	Integrate all services CFR(s): 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. This ELEMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure coordination of patient care for 1 of 1 patient (Patient #5) whose payor source was VA and whose record was reviewed. This resulted in missed opportunities to adjust the POC to ensure patient safety. Findings include:	{G 606}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137105	A. BUILDING _____ B. WING _____	R 04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{G 606}	Continued From page 25 Patient #5 was a 72 year old male admitted to the agency on 4/11/19, with a primary diagnosis of DM Type 2. He received SN services. His POC, for the certification period 4/11/19 to 6/09/19, and medical record from 4/12/19 to 4/18/19, were reviewed. Patient #5's payor source was identified as VA. The RNCM failed to integrate services to ensure Patient #5's safety. An example includes: Patient #5's medical record included a "Client Medication Report," reviewed 4/11/9, signed by the RNCM, which listed the following medications for DM: - Lantus insulin 70 units SQ BID - Novolog U-100 insulin sliding scale SQ TID Patient #5's medical record included a POC, which stated SN services would be provided 1 time per week for 8 weeks. Patient #5's medical record included an SN visit note, dated 4/15/19, signed by the RNCM which stated: - "WHAT TYPE OF ANTI-DIABETIC MEDICATIONS IS THE PATIENT CURRENTLY TAKING?...INSULIN" - "CAN THE PATIENT SAFELY, EFFECTIVELY AND CONSISTENTLY SELF-ADMINISTER INSULIN?...NO" - "INDICATE THE HEALTH CONDITIONS, BODY STRUCTURE/FUNCTION IMPAIRMENTS	{G 606}		

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 606}	Continued From page 26 THAT EXPLAIN WHY THE PATIENT CANNOT SAFELY, CONSISTENTLY, AND EFFECTIVELY SELF-ADMINISTER INSULIN...COGNITIVE/BEHAVIORAL IMPAIRMENT" - "DETAILS OF COGNITIVE/BEHAVIORAL IMPAIRMENT...DOCUMENTED MEDICAL HISTORY OF DEMENTIA" - "IS A CAREGIVER AVAILABLE, WILLING, AND ABLE TO SAFELY, CONSISTENTLY, AND EFFECTIVELY ADMINISTER PATIENT'S INSULIN?...NO" - "PLEASE EXPLAIN:...PATIENT LIVES ALONE AND REFUSES ASSISTANCE AT THIS TIME" - "NEURO/COG/BEHAVIORAL ASSESSMENT FINDINGS:...IMPAIRED SHORT TERM MEMORY...JEOPARDIZES SAFETY THROUGH ACTIONS..." - "CURRENT ACTIVITY LIMITATIONS INCLUDE: MOBILITY WALKING MOVING AROUND USING EQUIPMENT SELF CARE WASHING ONESELF CARING FOR BODY PARTS TOILETING DRESSING LOOKING AFTER ONE'S OWN HEALTH DOMESTIC LIFE ACQUISITION OF GOODS AND SERVICES PREPARATION OF MEALS DOING HOUSEWORK	{G 606}		

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 606}	Continued From page 27 USING TRANSPORTATION ASSISTING OTHERS" Patient #5's medical record did not include how the agency was keeping him safe related to his documented activity limitations, cognitive impairment, and insulin administration. Patient #5's medical record did not include documentation the RNCM notified Patient #5's physician or VA Case Manager regarding his identified needs in order to keep him safe. The Regional Administrator was interviewed on 4/18/19, beginning at 5:13 PM, and Patient #5's medical record was reviewed in her presence. She confirmed the RNCM did not document if he contacted Patient #5's physician or VA Case Manager regarding his identified safety needs. The Regional Administrator confirmed the documentation was unclear how the RNCM was keeping Patient #5 safe. The RNCM failed to integrate services to ensure Patient #5's safety.	{G 606}		
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 medical record review and staff interview, it was determined the agency failed to ensure care was coordinated to meet the needs of 2 of 9 patients (#1 and #4) whose records were reviewed. This had the potential to result in unmet patient needs. Findings include:	G 608		

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G 608	Continued From page 28 1. Patient #4 was a 78 year old male admitted to the agency on 4/11/19, with a primary diagnosis of left foot ulcer. Additional diagnoses included pain and insulin dependent diabetes. He received SN and MSW services. His POC, for the certification period 4/11/19 to 6/09/19, and medical record from 4/12/19 to 4/18/19, were reviewed. The American Diabetes Association website, accessed 4/22/19, stated: "The American Diabetes Association suggests the following targets for most nonpregnant adults with diabetes..." - "Before a meal (preprandial plasma glucose): 80 - 130 mg/dl" - "1 - 2 hours after beginning of the meal (Postprandial plasma glucose): Less than 180 mg/dl" Patient #4's medical record included an SN visit note, dated 4/17/19, signed by an LPN, which stated "Random Blood Sugar...483 [mg/dl]." The LPN did not document if she contacted Patient #4's RNCM regarding his elevated blood glucose level. The Regional Administrator was interviewed on 4/18/19, beginning at 3:47 PM, and Patient #4's medical record was reviewed in her presence. She confirmed the LPN did not document if she contacted Patient #4's RNCM regarding his elevated blood glucose level. The RNCM was not informed of Patient #4's	G 608		

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G 608	Continued From page 29 change in condition. 2. Patient #1 was an 81 year old male admitted to the agency on 4/11/19, for care following a left TKA. Additional diagnoses included ASHD and HTN. He received SN and PT services. His record, including the POC, for the certification period 4/11/19 to 6/09/19, and record content between 4/12/19 and 4/18/19, was reviewed. Patient #1's record included a "Client Coordination Note Report," dated Saturday 4/13/19, signed by the on-call RN. The note stated Patient #1 called the agency complaining of bleeding at the site of his dressing, and stated his right foot up to his groin was red and swollen. The note stated the RN advised Patient #1 to go to the emergency room. Patient #1's record did not include documentation of communication with his RNCM regarding the change in his condition. It did not document follow up communication with Patient #1 to determine whether he went to the emergency room. Patient #1's record did not document communication with his physician regarding the change in his condition. Patient #1's next SN visit note was dated 4/17/19, 4 days later, and signed by an LPN. The note did not document coordination with the RNCM regarding Patient #1's status. During an interview on 4/18/19 at 5:30 PM, the Regional Administrator reviewed Patient #1's record and confirmed there was no documentation of communication with his RNCM or his physician regarding the change in his condition or the agency's recommendation he go	G 608		

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 608	Continued From page 30 to the emergency room. The agency failed to ensure coordination of care between SN staff and the physician regarding the change in Patient #1's condition.	G 608		

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

18 April 2019

Management team met to determine a plan to address deficiencies from CMS-2567. In order to assure compliance with all identified survey deficiencies, a plan was developed to ensure proper training, in servicing, implementation and follow up.

Implementation of Plan:

Regional Administrator and designees to conduct in service to Branch Directors, Clinical Field Staff Supervisors, RN, PT, SLP staff on Policy S2.0 Admissions/Client Assessment. With emphasis on sections 2.1, 2.2, 2.3, 2.4, 3.1, 3.2,3.3,3.4, 3.6, 3.7, 3.8, 4.1, 4.2, 4.2.4, 4.2.5, 4.4, 4.5, 4.6. Education to include proper vetting of each admission to ensure the agency has the staffing, tools and resources needed to carry out the physician's orders. To ensure the physician's orders comply with Medicare guidelines when applicable, and ensure a complete Plan of Care is subsequently developed based on the findings from the initial assessment. Evaluations for additional disciplines will be completed as ordered by a physician. A welcome call will be made to the patient prior to admission to ensure the patient has or is able to obtain anything needed to ensure the plan of care is carried out per the physician's order. The patient will be notified of the technical procedure that will be performed and information concerning the aspects of his/her condition that relates to the care that will be provided.
A resource information folder to be left in the home that includes but not limited to Patient Information Report, Vital signs log, Teaching guides and materials, emergency preparedness and information on complaints, grievances, and the Home Health Hotline.

(See attachment 1)

In service/Training:
In service/Training will be completed on or before May 10, 2019.

Follow up:
All in services/training will occur on or before May 10, 2019. Chart audits of 100% of charts with SOE starting April 1st will be audited by the clinical audit team. Clinical Field Staff Supervisors will audit 100% of case conference notes focusing on the Coordination notes will be completed weekly by the local branch directors and monthly by the clinical operations auditor on an ongoing basis for a period of 3 months to ensure the welcome call has been completed and documented appropriately. Performance Improvement project will be implemented and monitored by the Regional Administrator to ensure on-going education and compliance. Regional administrator will also ensure that items are reviewed and addressed monthly through on-site supervisory visits, quarterly QAPI meetings, and regularly scheduled strategic planning meetings. Coordination will occur face to face, via email, telephone and or webinar

Compliance:
Compliance will be met on or before May 10, 2019
If 100 % ongoing compliance is not met, re-education will be completed with disciplinary action where appropriate. Ongoing audits monthly will occur to ensure ongoing compliance for a period of 1

G572 Plan of Care
CFR(s):484.60(a)(1)

18 April 2019

Management team met to determine a plan to address deficiencies from CMS-2567. In order to assure compliance with all identified survey deficiencies, a plan was developed to ensure proper training, in servicing, implementation and follow up.

Implementation of Plan:

Regional Administrator to conduct in service to Branch Directors, Clinical Field Staff Supervisors, RN, PT, SLP staff on Policy S2.0 Admissions/Client Assessment with emphasis on sections 3.0 and 4.2.7. All staff to be in serviced on Policy S6.0 The Physician's role with emphasis on section 3.5.
RN, SLP, PT staff will receive Case Management training/ In service. All clinical staff will receive in service/training regarding comprehensive assessment. Focusing on the overall patient assessment, proper notification of the physician for assessment findings outside of the parameter including but not limited to Vital signs, blood glucose readings and any adverse assessment findings, and ensuring vital sign parameters exist for all patients on the Plan of Care.
Notification of physician for missed visits, changes to the plan of care including but not limited to any requested frequency or treatment changes.
(See attachments 1 and 2)

In service/Training:
In service/Training will be completed on or before May 10, 2019.

Follow up:
All in services/training will occur on or before May 10, 2019. Initial chart audit of 100% of all charts will be completed by clinical audit team. Ongoing chart audits of at least 25% will be completed weekly by the local branch directors or designee and monthly by the clinical operations auditor. Performance Improvement project will be implemented and monitored by the Regional Administrator to ensure on-going education and compliance is maintained. Regional administrator will also ensure that items are reviewed and addressed monthly through on-site supervisory visits, quarterly QAPI meetings, and regularly scheduled strategic planning meetings. Coordination will occur face to face, via email, telephone and or webinar with potential of more frequent on-site supervisory visits for deficient practices.

Compliance:
Compliance will be met on or before May 10, 2019
If 100 % ongoing compliance is not met, re-education will be completed with disciplinary action where appropriate. Ongoing audits will occur monthly to ensure ongoing compliance for a period of 12 months.

G574 Plan of Care must include the following
CFR(s): 484.60 (a)(2)(i-xvi)

18 April 2019

Management team met to determine a plan to address deficiencies from CMS-2567. In order to assure compliance with all identified survey deficiencies, a plan was developed to ensure proper training, in servicing, implementation and follow up.

Implementation of Plan:

Regional Administrator and/or designee to conduct in service to Branch Directors, Clinical Field Staff Supervisors, RN, PT, SLP staff on Policy S2.0 Admissions/Client Assessment with emphasis on sections 3.0 and 4.2.7. All staff to be in serviced on Policy S6.0 The Physician's role with emphasis on section 3.5. RN, SLP, PT staff will receive Case Management training/ In service. All clinical staff will receive in service/training regarding comprehensive assessment. In service to include proper documentation of all aspects of the plan of care, including but not limited to; Medications and durable medical equipment. As well as mitigation of adverse events for at risk patients such as nutritional risk, fall risk and risk for skin breakdown. In service will also include medication reconciliation, risk for pain and interventions for pain relief and specific wound care and any supplies needed to complete the wound care.
(see attachments 1 and 2)

In service/Training:
In service/Training will be completed on or before May 10, 2019.

Follow up:
All in services/training will occur on or before April 12, 2019. Initial chart audit of 100% of charts will be completed by clinical audit team. Ongoing chart audits of 25% will be completed weekly by the local branch directors or designee and monthly by the clinical operations auditor. Performance Improvement project will be implemented and monitored by the Regional Administrator to ensure on-going education and compliance. Regional administrator will also ensure that items are reviewed and addressed monthly through on-site supervisory visits, quarterly QAPI meetings, and regularly scheduled strategic planning meetings. Coordination will occur face to face, via email, telephone and or webinar with potential of more frequent on-site supervisory visits for deficient practices.

Compliance:
Compliance will be met on or before May 10, 2019
If 100 % ongoing compliance is not met, re-education will be completed with disciplinary action where appropriate. Ongoing audits will occur monthly to ensure ongoing compliance for a period of 1 year.

G580: Only as ordered by a physician
CFR(s): 484.60(b)(1)

18 April 2019

Management team met to determine a plan to address deficiencies from CMS-2567. In order to assure compliance with all identified survey deficiencies, a plan was developed to ensure proper training, in servicing, implementation and follow up.

Implementation of Plan:

Regional Administrator to conduct in service to all clinical staff regarding policy S6.0 The physicians Role. (see attachment 2) On site supervisory visits will be made with 100% of staff to ensure compliance with Plan of Care is followed and appropriately documented to include but not limited to review of plan of care and physician's orders, medication changes, conditions to report.

In service/Training:
In service/Training and on site supervisory visits will be completed on or before May 10, 2019.

Follow up:
All in services/training and initial on site visits will occur on or before May 10, 2019. Ongoing chart audits of 25% will be completed weekly by the local branch directors or designee and monthly by the clinical operations auditor. Performance Improvement project will be implemented and monitored by the Regional Administrator to ensure on-going education and compliance. Regional administrator will also ensure that items are reviewed and addressed monthly through on-site supervisory visits, quarterly QAPI meetings, and regularly scheduled strategic planning meetings. Coordination will occur face to face, via email, telephone and or webinar with potential of more frequent on-site supervisory visits for deficient practices.

Compliance:
Compliance will be met on or before May 10, 2019
If 100 % ongoing compliance is not met, re-education will be completed with disciplinary action where appropriate. Ongoing audits will occur to ensure ongoing compliance for a period of 12 months.

G584 Verbal orders
CFR(s): 484.60(b)(3)(4)

18 April 2019

Management team met to determine a plan to address deficiencies from CMS-2567. In order to assure compliance with all identified survey deficiencies, a plan was developed to ensure proper training, in servicing, implementation and follow up.

Implementation of Plan:

Regional Administrator to conduct in service to all clinical staff regarding policy S6.0 The physicians Role with emphasis on section 2.2. Focusing on taking and writing of all verbal orders that are received. Ensuring that it is documented in the Coordination notes as well as written as a verbal order. That if the verbal order is in relation to medications that the new medication is also added to the medication list and if wound care is initiated, there is an order from the physician.
(see attachment 2)

In service/Training:
In service/Training will be completed on or before May 10, 2019.

Follow up:
All in services/training and 100% initial chart review will occur on or before May 10, 2019. Ongoing chart audits of at least 25% of charts will be completed weekly by the local branch directors or designee and monthly by the clinical operations auditor. Performance Improvement project will be implemented and monitored by the Regional Administrator to ensure on-going education and compliance. Regional administrator will also ensure that items are reviewed and addressed monthly through on-site supervisory visits, quarterly QAPI meetings, and regularly scheduled strategic planning meetings. Coordination will occur face to face, via email, telephone and or webinar with potential of more frequent on-site supervisory visits for deficient practices.

Compliance:
Compliance will be met on or before May 10, 2019
If 100 % ongoing compliance is not met, re-education will be completed with disciplinary action where appropriate. Ongoing audits will occur to ensure ongoing compliance for a period of 12 months.

G590 Promptly alert relevant physician of changes
CFR(s):484.60(c)(1)
18 April 2019

Management team met to determine a plan to address deficiencies from CMS-2567. In order to assure compliance with all identified survey deficiencies, a plan was developed to ensure proper training, in servicing, implementation and follow up.

Implementation of Plan:

Regional Administrator to conduct in service to all clinical staff regarding policy S6.0 The physicians Role with emphasis on section 3.5. Focusing on ensuring that the physician is notified of change in patient condition. An initial audit of 100% of charts will occur to review compliance.
(see attachment 2)

In service/Training:
In service/Training and initial chart audit will be completed on or before May 10, 2019.

Follow up:
All in services/training and initial chart audit will occur on or before May 10, 2019. Ongoing chart audits of at least 25% will be completed weekly by the local branch directors or designee and monthly by the clinical operations auditor. Performance Improvement project will be implemented and monitored by the Regional Administrator to ensure on-going education and compliance. Regional administrator will also ensure that items are reviewed and addressed monthly through on-site supervisory visits, quarterly QAPI meetings, and regularly scheduled strategic planning meetings. Coordination will occur face to face, via email, telephone and or webinar with potential of more frequent on-site supervisory visits for deficient practices.

Compliance:
Compliance will be met on or before May 10, 2019
If 100 % ongoing compliance is not met, re-education will be completed with disciplinary action where appropriate. Ongoing audits will occur to ensure ongoing compliance for a period of 12 months.

G606 Integrate all services
CFR(s): 484.60(d)(3)

18 April 2019

Management team met to determine a plan to address deficiencies from CMS-2567. In order to assure compliance with all identified survey deficiencies, a plan was developed to ensure proper training, in servicing, implementation and follow up.

Implementation of Plan:

Regional Administrator to conduct in service to all clinical staff regarding coordination of care between disciplines, utilizing the Clinician meeting in service. Discussing scenarios and events when specific care coordination is required, how to best communicate and document the coordination in the clinical record. An initial chart audit of 100% will be conducted by the clinical audit team.

In service/Training:
In service/Training and initial chart audit will be completed on or before May 10, 2019.

Follow up:
All in services/training and initial chart review of 100% of records by clinical audit team will occur on or before May 10, 2019. Ongoing chart audits of at least 25% will be completed weekly by the local branch directors or designee and monthly by the clinical operations auditor. Performance Improvement project will be implemented and monitored by the Regional Administrator to ensure on-going education and compliance. Regional administrator will also ensure that items are reviewed and addressed monthly through on-site supervisory visits, quarterly QAPI meetings, and regularly scheduled strategic planning meetings. Coordination will occur face to face, via email, telephone and or webinar with potential of more frequent on-site supervisory visits for deficient practices.

Compliance:
Compliance will be met on or before May 10, 2019
If 100 % ongoing compliance is not met, re-education will be completed with disciplinary action where appropriate. Ongoing audits will occur to ensure ongoing compliance for a period of 12 months.

G608 Coordinate care activity
CFR(s):484.60(d)(4)

18 April 2019

Management team met to determine a plan to address deficiencies from CMS-2567. In order to assure compliance with all identified survey deficiencies, a plan was developed to ensure proper training, in servicing, implementation and follow up.

Implementation of Plan:

Regional Administrator to conduct in service to all clinical staff regarding coordination of care between disciplines, caregiver, and physician utilizing the Clinician meeting in service. Discussing scenarios and events when specific care coordination is required, appropriate individuals to coordinate with i.e., Case Manager, physician, caregiver, patient or team member; how to best communicate and document the coordination in the clinical record. An initial chart audit of 100% will be completed by the clinical audit team.

In service/Training:
In service/Training and initial chart audit will be completed on or before April 12, 2019.

Follow up:
All in services/training and initial chart audit will occur on or before May 10, 2019. Ongoing chart audits of 25% will be completed weekly by the local branch directors, or designeee and monthly by the clinical operations auditor. Performance Improvement project will be implemented and monitored by the Regional Administrator to ensure on-going education and compliance. Regional administrator will also ensure that items are reviewed and addressed monthly through on-site supervisory visits, quarterly QAPI meetings, and regularly scheduled strategic planning meetings. Coordination will occur face to face, via email, telephone and or webinar with potential of more frequent on-site supervisory visits for deficient practices.

Compliance:
Compliance will be met on or before May 10, 2019.
If 100 % ongoing compliance is not met, re-education will be completed with disciplinary action where appropriate. Ongoing audits will occur to ensure ongoing compliance for a period of 12 months.