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FIRST CHOICE HOME HEALTHCARE, LLC	**2995 SOUTH JONES BLVD, SUITE A LAS VEGAS, NV 89146**

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G 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the Medicare re-certification survey under 42 CFR Part 484 - Home Health Services, conducted at your agency from 6/30/09 through 7/7/09. The active census on the first day of the survey was 77. Seventeen clinical records were reviewed, including two closed records. Three home visits were conducted. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	G 000		
G 116	484.10(f) HOME HEALTH HOTLINE The patient has the right to be advised of the availability of the toll-free HHA hotline in the State. When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.	G 116		

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

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 116	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the agency failed to ensure the availability of the toll free home health hotline phone number, along with appropriate situations in which to use it, was explained to 2 of 3 patients interviewed (#1, 2). Findings include: Patient #1 Patient #1 was admitted on 7/9/08 with diagnoses including paraplegia, neurogenic bowel, constipation and hypertension. On 7/1/09 at 10:15 AM during a visit to the patient's home, Patient #1 revealed he was not aware there was a toll free home health hotline phone number. A home folder containing the toll free home health hotline phone number could not be found in Patient #1's home. Patient #2 Patient #2 was admitted on 6/10/09 with diagnoses including generalized muscle weakness, Parkinson ' s Disease, and atrial fibrillation. On 7/1/09 around 12:45 PM, Patient #2 indicated she was unaware of the existence of a home health hotline number.	G 116		
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply	G 121		

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to professionals furnishing services in an HHA.

This STANDARD is not met as evidenced by:
Based on observation, policy review and accepted professional standards, the agency failed to ensure field staff observed principles of infection control and bag technique for 3 of 3 patients observed (Patients #1, 2, 3).

Findings include:

Patient #1

Patient #1 was admitted on 7/9/08 with diagnoses including paraplegia, neurogenic bowel, constipation and hypertension.

On 7/1/09 at 10:15 AM during a visit to Patient #1's home, the certified nursing assistant (CNA) reached into the nursing bag several times with gloves on before, during and after providing personal care for the patient.

Patient #2

Patient #2 was admitted on 6/10/09 with diagnoses including generalized muscle weakness, Parkinson ' s Disease, and atrial fibrillation.

On 7/1/09 at 11:57 AM, the physical therapist (PT) arrived at Patient #2's door (apartment inside an assisted living facility).

Explaining that he had already washed his hands in the downstairs public restroom, the PT indicated he and the patient "usually go out into the hallway because there is more room for the

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G 121	Continued From page 3 patient to walk around." After walking to the end of the hall, Patient #2 sat down and the PT measured her blood pressure. (The PT had left the automatic blood pressure monitoring device on the table out in the hallway.) The PT carried no bag or hand sanitizer. After several seated exercises and some additional ambulation around the facility, we returned to the corner where the blood pressure cuff was still sitting on the table. The PT measured the patient's blood pressure again, walked Patient #2 back to her apartment and then the PT departed. Patient #3 Patient #3 was admitted on 6/2/09 with diagnoses including pressure ulcer left foot, hypertension, senile dementia and anxiety disorder. The patient's room was in a secured assisted living facility. On 7/1/09 at 2:05 PM, Employee #5 placed her nursing bag on Patient #3's table after opening the home folder and placing it underneath the bag. Employee #5 washed her hands at the sink, using the soap there. Having no paper towels with which to dry her hands, she used toilet paper from Patient #3's bathroom. Employee #5 woke Patient #3 and, without gloves on, touched and looked at the (now) scabbed pressure ulcer on the patient's left foot. Without washing her hands, Employee #5 reached into	G 121		

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G 121	Continued From page 4 her nursing bag and brought out a pair of gloves and wound care supplies. After cleaning Patient #3's wound, Employee #5 kept the same gloves on and reached into her nursing bag for a measuring device. Employee #5 measured the wound and then removed her gloves and discarded the measuring device and gloves. Without washing her hands, Employee #5 reached into her bag for the dressing. Employee #5 had no scissors with her so she took the dressing out to the nursing station to borrow their scissors. Employee #5 returned to the room and placed the dressing over the scab on Patient #3's left foot. Employee #5 then reached into her bag and retrieved a blood pressure cuff, stethoscope and aural (ear) thermometer. After checking Patient #3's vital signs, Employee #5 placed the blood pressure cuff, stethoscope and thermometer into her bag without cleaning the equipment or her hands. According to the agency's policy on Bag Technique from "Mosby's Manual of Home Health Nursing Procedures" Second Edition by Robyn Rice (also considered to provide professional standards of practice), "... 3. Once inside the patient's home ... spread the newspaper. 4. Place the bag on the newspaper... 6. Open the nursing bag, and remove items that are needed to wash the hands. Handwashing supplies should be kept at the top of the bag. Close the bag Use the nursing bag as few times as possible. 7. Take items to wash the hands (liquid soap, paper towels) to the sink area.	G 121		

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G 121	Continued From page 5 Spread out one paper towel on which to place other items. The second and third is used for washing and drying the hands before and after care has been provided (additional paper towels may be required if wound care or other procedures are being provided) ... 10. After providing care, clean all equipment with soap and water or a home health agency-approved disinfectant before returning it to the bag ... 11. Wash hands. ... 12. When leaving the patient's home, pick up the bag and place the newspaper that was underneath it in the family trash..."	G 121		
G 143	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. This STANDARD is not met as evidenced by: Based on record review and document review, the agency failed to ensure all personnel providing services maintained liaison and effectively coordinated care outlined in the plan of care for 13 of 17 patients (Patients #1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 13, 16, 17). Findings include: Patient #1 Patient #1 was admitted on 7/9/08 with diagnoses including paraplegia, neurogenic bowel, constipation and hypertension. On Patient #1's Skilled Nursing Visit Note(SNVN) dated 5/29/09, the registered nurse (RN)	G 143		

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documented, "Patient R (right) toe was avulsed about 3 days ago. No active bleeding now ..."

On a SNVN dated 5/26/09, the same RN documented nothing about Patient #1 having an avulsed toe (nail). There was no documentation in the clinical record to indicate the patient's physician was notified of the problem. There was no documentation to indicate the director of nursing was made aware of a problem with Patient #1's toe.

Patient #2

Patient #2 was admitted on 6/10/09 with diagnoses including generalized muscle weakness, Parkinson's Disease, and atrial fibrillation.

Patient #2's clinical record contained skilled nurse (SN) notes and physical therapy notes. The nursing notes had a specific area where the SN could indicate they spoke with another discipline regarding the patient. These areas were all blank on the SN notes. The PT notes lacked documented evidence the PT had communicated with the nurse.

Patient #4

Patient #4 was admitted on 4/16/09 with diagnoses including abnormality of gait, hypertension, congestive heart failure and osteoarthritis of the pelvis.

Patient #4 was seen by skilled nursing (SN) and physical therapy (PT). The clinical record lacked documentation indicating SN and PT communicated with each other regarding the

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patient's status and progress.

Patient #5

Patient #5 was admitted on 10/17/08 with diagnoses including paralysis agitans, non-insulin dependent diabetes mellitus, hypertension and osteoporosis.

Patient #5 was seen by skilled nursing (SN) and physical therapy (PT). The clinical record lacked documentation indicating SN and PT communicated with each other regarding the patient's status and progress.

Patient #6

Patient #6 was admitted on 2/18/08 with diagnoses including generalized muscle weakness, abnormality of gait, hypertension and long-term use of anticoagulant.

Patient #6 was seen by skilled nursing (SN), certified nursing assistant (CNA), physical therapy (PT), occupational therapy (OT) and a medical social worker (MSW).

Patient #6's clinical record contained four physician's orders (dated 2/17/09 (a resumption of care), 2/19/09, 3/6/09 and 3/10/09) to change the frequency of the CNA visits. All four orders were prepared and signed by four different people. The clinical record lacked documented evidence the four people communicated with each other regarding the changes to the CNA frequencies.

Patient #7

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G 143	Continued From page 8 Patient #7 was admitted on 5/4/09 with diagnoses including peripheral vascular disease, peripheral neuropathy, gout and hypertension. Patient #7 was seen by skilled nursing (SN), physical therapy (PT) and occupational therapy (OT). The SN, PT and OT notes lacked documented evidence of communication among the three disciplines regarding Patient #7's condition and progress. On the eighth day after admission to home health care, Patient #7 was re-hospitalized. The patient returned home on 5/14/09. A resumption of care visit was done on 5/19/09 by the RN. Patient #7's clinical record lacked documented evidence of communication among the involved disciplines after the resumption of care was completed on 5/19/09. Patient #8 Patient #8 was admitted on 5/18/09 with diagnoses including generalized muscle weakness, pulmonary embolism, debility, hypertension and general osteoarthrosis. Patient #8 was being seen by skilled nursing (SN) and physical therapy (PT). Patient #8's clinical record lacked documentation indicating SN and PT were communicating with one another regarding the patient's status, progress, etc. Patient #9	G 143		

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G 143	Continued From page 9 Patient #9 was admitted on 2/23/09 with diagnoses including generalized muscle weakness, lumbago, osteoarthrosis, abnormality of gait and coronary artery disease. Patient #9 was seen by skilled nursing (SN) and physical therapy (PT). The SN notes and the PT notes lacked documented evidence the two disciplines communicated with each other regarding Patient #9's status, progress, etc. Patient #10 Patient #10 was admitted on 4/27/09 with diagnoses including pressure ulcer, non-insulin dependent diabetes mellitus, hypertension, senile dementia and failure to thrive. Patient #10 was seen by skilled nursing (SN), physical therapy (PT) and occupational therapy (OT). The clinical record lacked documented evidence the three disciplines communicated with each other regarding the patient's status and progress. Patient #11 Patient #11 was admitted on 6/22/09 with diagnoses including insulin dependent diabetes mellitus, abnormality of gait, hypertension, lumbago and end stage renal disease. Patient #11 was seen by skilled nursing (SN), physical therapy (PT), certified nursing assistant (CNA) and a dietician.	G 143		

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Patient #11's clinical record lacked documented evidence the four disciplines (SN, PT, CNA, dietician) communicated with each other regarding the patient's status and/or progress.

Patient #13

Patient #13 was admitted on 1/30/09 with diagnoses including insulin dependent diabetes mellitus, neuropathy, hemiplegia, chronic pain and general osteoarthrosis.

Patient #13 was seen by skilled nursing (SN) and physical therapy (PT). The clinical record lacked documentation indicating SN and PT communicated with each other regarding the patient's status and progress.

Patient #16

Patient #16 was admitted on 9/4/08 with diagnoses including debility, chronic obstructive asthma, hypertension, vulvar cancer and congestive heart failure.

Patient #15 was seen by skilled nursing (SN) and a certified nursing assistant (CNA). The clinical record lacked documentation indicating the two disciplines communicated with each other regarding the patient's status and progress.

Patient #17

Patient #17 was admitted on 1/2/08 with diagnoses including congestive heart failure, dementia and anemia.

Patient #17 was seen by skilled nursing (SN), certified nursing assistant (CNA) and physical

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G 143	Continued From page 11 therapy (PT). The clinical record lacked documentation indicating the three disciplines communicated with each other regarding the status and progress of the patient. According to the agency's policy, Coordination of Patient Services, "First Choice Home Health Care staff members provide coordination for client services to establish effective reporting, interchange and coordinated client evaluation and care through communication between field staff and in-office clinical personnel. It is the responsibility of the office clinical nursing staff to assure that coordination of care is done...The office nursing management team shall be the conduit of communication between the disciplines and shall document their discussion on the 'Care Coordination Note' form."	G 143		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on interview, record review and policy review, the agency failed to ensure clinical records included notes from case conferences wherein effective interchange and coordination of patient care occurred for 7 of 17 patients being seen by more than one discipline (Patients #1, 5, 6, 7, 8, 9, 17). Findings include:	G 144		

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G 144	Continued From page 12 Patient #1 Patient #1 was admitted on 7/9/08 with diagnoses including paraplegia, neurogenic bowel, constipation and hypertension. Patient #1 was being seen by skilled nursing (SN), certified nursing assistant (CNA) and physical therapy (PT). The patient's clinical record lacked documented evidence of a case conference for the past two months. Patient #5 Patient #5 was admitted on 10/17/08 with diagnoses including paralysis agitans, non-insulin dependent diabetes mellitus, hypertension and osteoporosis. Patient #5 was being seen by skilled nursing (SN) and physical therapy (PT). Patient #5's clinical record included two documents titled "Case Conference" and dated 2/11/09 and 6/13/09. The only documentation on the forms was by SN. There was no documented evidence PT participated in the case conference. Patient #6 Patient #6 was admitted on 2/18/08 with diagnoses including generalized muscle weakness, abnormality of gait, hypertension and long-term use of anticoagulant. Patient #6 was seen by skilled nursing (SN), certified nursing assistant (CNA), physical therapy (PT), occupational therapy (OT) and a medical social worker (MSW).	G 144		

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G 144	Continued From page 13 Patient #6's clinical record contained a case conference dated 12/12/08. The clinical record lacked documented evidence of a case conference since 12/12/08. Patient #7 Patient #7 was admitted on 5/4/09 with diagnoses including peripheral vascular disease, peripheral neuropathy, gout and hypertension. Patient #7 was being seen by skilled nursing (SN) and occupational therapy (OT). Patient #7's clinical record contained a case conference form dated 6/28/09 with only the SN portion filled in. There was no documented evidence OT participated in the case conference. Patient #8 Patient #8 was admitted on 5/18/09 with diagnoses including generalized muscle weakness, pulmonary embolism, debility, hypertension and general osteoarthrosis. Patient #8 was seen by skilled nursing (SN) and physical therapy (PT). Patient #8's clinical record contained a case conference note dated 5/18/09 and filled out by SN only. There was no documented evidence PT participated in the case conference. Patient #9 Patient #9 was admitted on 2/23/09 with diagnoses including generalized muscle	G 144		

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weakness, lumbago, osteoarthrosis, abnormality of gait and coronary artery disease.

Patient #9 was seen by skilled nursing (SN) and physical therapy (PT).

Patient #9's clinical record included a case conference dated 2/23/09 which was filled out by SN. There was no documented evidence PT participated in the case conference.

Patient #17

Patient #17 was admitted on 1/2/08 with diagnoses including congestive heart failure, dementia and anemia.

Patient #17's clinical record lacked documented evidence of case conference being held during the certification period of 1/2/08 through 3/1/08 (patient was admitted to an acute care facility on 2/14/09).

On 6/30/09 at 2:30 PM, the director of nursing (DON) indicated case conferences were held every week and every patient was discussed every 60 days.

On 7/7/09 in the morning, the DON indicated case conferences were "held within 7 days after admission, then 30 days after admission and at the time of recertification; they can be by telephone."

On 7/7/09 in the morning, the director of nursing agreed that a case conference of one is not a case conference.

According to the agency's policy, Client Case

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE HOME HEALTHCARE, LLC	**2995 SOUTH JONES BLVD, SUITE A LAS VEGAS, NV 89146**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 144	Continued From page 15 Conference (date effective, revised and approved blank), "... 1. Case Conferences are conducted to all newly admitted patient to HHA (home health agency) within 7 days ... 6. The content and results are documented on the Case Conference forms, filed and kept by the Director of Patient Care Services ... 8. The content and result are documented on the case conference forms & to be filed in patient chart..."	G 144		
G 145	484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. This STANDARD is not met as evidenced by: Based on record review and policy review, the agency failed to prepare and send a written 60-day summary which described 1) the patients' status at the beginning of the certification period; 2) care and treatments provided during the certification period; and 3) response to the care, treatment and teaching provided for 10 of 17 patients (Patients #1, 4, 5, 6, 9, 10, 13, 15, 16, 17). Findings include: Patients #1, 4, 5, 6, 9, 10, 13, 15, 16 and 17 were all on service for more than one 60-day certification period. The 60-day summaries for patients #1, 4, 5, 6, 9, 10, 13, 15, 16 and 17 did not include 1) the patients' status at the beginning of each certification period (i.e., size and description of wounds, blood sugar ranges, mental status and ability to care for self, etc.) ; 2) the different types	G 145		

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G 145	Continued From page 16 of care provided (wound care, intravenous infusions, insulin preparation and administration, teaching of disease process and management, lab draws, falls and/or injuries, rehospitalization), medication changes that occurred, treatments provided (physical therapy, occupational therapy), out-patient dialysis; and 3) the patients' and/or caregivers' response to the care, treatments and teaching. The agency's undated policy, 60 Day Summary, indicated "... 2. Update patient's history, medication and treatment... 4. Identify new problems and needs or changes in patient treatment plan..."	G 145		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on interview, record review and policy review, the agency failed to ensure care provided followed the written plan of care established by the physician for 12 of 17 patients (Patients #1, 2, 3, 4, 5, 6, 7, 10, 11, 13, 15, 16). Findings include: Patient #1 Patient #1 was admitted on 7/9/08 with diagnoses including paraplegia, neurogenic bowel, constipation and hypertension. Patient #1's Plan of Care (POC) for the	G 158		

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certification period of 5/5/09 through 7/3/09 included orders for skilled nursing (SN) visits two times a week. The clinical record lacked documentation of a second SN visit the week of 5/10/09.

Patient #2

Patient #2 was admitted on 6/10/09 with diagnoses including generalized muscle weakness, Parkinson ' s Disease, and atrial fibrillation.

The Plan of Care (POC) indicated Patient #2 was to have a certified nursing assistant (CNA) twice a week for personal care assistance.

On 7/7/09 in the morning, the intake coordinator explained, "The patient (#2) refused (the CNA)."

The clinical record lacked a physician's order cancelling the CNA.

Patient #3

Patient #3 was admitted on 6/2/09 with diagnoses including pressure ulcer inner aspect of left large toe area, hypertension, senile dementia and anxiety disorder.

During the admission of Patient #3 on 6/2/09, the registered nurse (RN) documented on the "Nurses Weekly Skin & Wound Progress" note dated 5/2/09, "Cleanse c (with) NS (normal saline) pat dry apply triple antibiotic cover c DSD (dry sterile dressing) wrap lightly c Kerlix (long gauze) and secure c paper tape.

On the OASIS comprehensive adult nursing

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assessment under "Additional notes on skilled care provided this visit," the RN wrote, "...Cleansed with NS c DSD applied and paper tape to secure."

According to the POC dated 6/2/09 for Patient #3, the wound care orders were "Cleanse with NS apply DSD 2X2, secure with paper tape three times a week and prn (as needed)."

Patient #3's clinical record contained a skilled nursing visit note (SNVN) dated 6/3/09 indicating the RN "cleansed wound c NS pat dried Neosporin applied to wound covered with 2X2 followed by Kerlix wrap and paper tape to secure."

The SNVN dated 6/5/09 lacked documentation regarding wound care provided for Patient #3.

On 6/8/09, the RN managing Patient #3's case wrote a physician's order that read, "Wound care: once a week. SN to cleanse the wound with NSS (normal saline solution). Pat dry. Apply Hydrogel with Tegaderm. Cover area with DSD (dry sterile dressing) and secure with tape."

Documentation in the clinical record included SNVNs dated 6/8/09, 6/9/09, 6/13/09, 6/15/09, 6/18/09, 6/19/09, 6/22/09 and 6/24/09 which all indicated the LPN "Removed Duoderm, cleansed with NS 0.9%, pat dry with 4X4 gauze, apply Duoderm."

The clinical record included four "Nurses Weekly Skin & Wound Progress" notes, dated 6/2/09, 6/12/09, 6/17/09 and 6/24/09.

According to the agency's policy and procedure

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G 158	Continued From page 19 regarding wound assessment and documentation, "... For consistent evaluation, it is advisable for the case manager to measure/stage the wound the first visit each week ..." Patient #4 Patient #4 was admitted on 4/16/09 with diagnoses including abnormality of gait, hypertension, congestive heart failure and osteoarthritis of the pelvis. The Plan of Care (POC) for Patient #4 included orders for a medical social worker (MSW) to evaluate the patient's situation and assist with placement in a safe environment. The clinical record for Patient #4 lacked documented evidence of a visit by the MSW. The clinical record lacked documentation indicating the MSW tried to contact the patient and/or the patient's son who was the primary caregiver. A physician's order dated 5/14/09 indicated SN was to visit Patient #4 "2W1" (two times a week for one week). The clinical record for Patient #4 contained a SN note dated 5/15/09. The clinical record lacked documented evidence of a second visit being made that week (the 15th was a Friday and the visit week ended on Saturday). There was no visit note for Saturday. The POC included orders for physical therapy (PT) to see Patient #4 one time a week for one week and then, two times a week for five weeks. The clinical record for Patient #4 lacked	G 158		

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G 158	Continued From page 20 documented evidence PT saw the patient during the week of 4/19/09. Patient #5 Patient #5 was admitted on 10/17/08 with diagnoses including paralysis agitans, non-insulin dependent diabetes mellitus, hypertension and osteoporosis. A physician's order dated 5/29/09 (Friday) indicated Patient #5 was to be seen by a skilled nurse (SN) "... daily x (times) 1 week." Nursing notes in the clinical record revealed Patient #5 was seen by SN on/29/09 and then one time a week for the two weeks following the order for SN daily for one week. The clinical record lacked documented evidence the patient was seen daily for one week, beginning on 5/29/09. Patient #6 Patient #6 was admitted on 2/18/08 with diagnoses including generalized muscle weakness, abnormality of gait, hypertension and long-term use of anticoagulant. For the certification period of 2/12/09 through 4/12/09, Patient #6 had a physician's order to be evaluated and treated by occupational therapy (OT). Patient #6 was evaluated by OT on 2/18/09. The frequency of OT visits ordered was one time a week for one week and then two times a week for three weeks, effective 2/18/09.	G 158		

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Patient #6's clinical record contained the OT evaluation visit note, two visit notes for the week of 2/22/09, no visit notes for the week of 3/1/09 and two visit notes for the week of 3/8/09 (which included the discharge note).

On 7/21/09 at 11:45 AM, the above frequency of OT visits for Patient #6 was confirmed with the director of nursing.

Patient #7

Patient #7 was admitted on 5/4/09 with diagnoses including peripheral vascular disease, peripheral neuropathy, gout and hypertension.

Patient #7 had physician orders to be seen by skilled nursing (SN) and occupational therapy (OT).

The original SN frequency was two times a week for three weeks. SN notes in the clinical record revealed Patient #7 was seen three times during the first week.

On 5/12/09, Patient #7 was admitted to an acute care facility secondary to a nosebleed.

On 5/19/09, the SN did a resumption of care visit. The SN frequency from 5/19/09 was to be two times a week for three weeks and then, one time a week for four weeks.

Patient #7's clinical record lacked documented evidence of a second SN visit during the fifth week of the nine week certification period.

A physician's order dated 5/22/09 was received to draw a PT/INR on Patient #7 "tomorrow."

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G 158	Continued From page 22 There was no SN note dated 5/23/09 in Patient #7's clinical record. A physician's order dated 6/16/09 was received to draw a repeat PT/INR on "Friday" (6/19/09). There was no SN note dated 6/19/09 in Patient #7's clinical record. On 6/23/09 a physician ' s order was received to draw a repeat PT/INR on Monday (6/29/09). There was no SN note dated 6/29/09 in Patient #7's clinical record. Patient #10 Patient #10 was admitted on 4/27/09 with diagnoses including pressure ulcer, non-insulin dependent diabetes mellitus, hypertension, senile dementia and failure to thrive. Patient #10 had a peripherally inserted central catheter (PICC) for administration of intravenous antibiotics. On 5/2/09, the nurse documented the Patient #10 was complaining of pain the previous evening and "...was given two tablets of Tylenol." Patient #10's clinical record lacked a physician's order for Tylenol. On 5/2/09, the clinical note for Patient #10 lacked documentation indicating the nurse administered the intravenous antibiotic. On 5/6/09, a registered nurse (RN) took a verbal order from Patient #10's physician. The order read, "... Hydrogel topical to right ankle ulcer; wound care to perirectal abscess; report to MD if	G 158		

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G 158	Continued From page 23 wound still not better after care." The 5/6/09 physician's order for Patient #10's perirectal abscess did not include the cleansing solution to be used, the type of dressing with which to cover the wound and the frequency of the wound care. There was no documentation in Patient #10's clinical record indicating the RN attempted to clarify the wound care orders with the physician. There was no documentation on the skilled nursing visit notes in Patient #10's clinical record referring to a perirectal abscess. Patient #11 Patient #11 was admitted on 6/22/09 with diagnoses including insulin dependent diabetes mellitus, abnormality of gait, hypertension, lumbago and end stage renal disease. Patient #11's clinical record included a physician's order dated 6/4/09 read, "Change SN (skilled nurse) frequency to BID (twice a day) for 58 days. Patient #11's clinical record included Missed Visit Reports (MVR) written by SN on 6/10/09 (one visit), 6/21/09 (both visits) and 6/26/09 (one visit). Patient #11's clinical record included MVRs written by physical therapy (PT) on 6/10/09, 6/22/09 and 6/24. Patient #11's clinical record lacked documented evidence of a physician's order to decrease the SN visit frequencies to account for the missed	G 158		

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G 158	Continued From page 24 visits. Patient #11's clinical record lacked documented evidence of a physician's order to decrease the PT visit frequencies for the week of 6/7/09. Patient #13 Patient #13 was admitted on 1/30/09 with diagnoses including insulin dependent diabetes mellitus, neuropathy, hemiplegia, chronic pain and general osteoarthrosis. Physical Therapy (PT) evaluated Patient #13 on 6/3. A physician's order was obtained for PT to see the patient two times a week for one week and then, three times a week for 5 weeks. According to the documentation in the clinical record, PT saw Patient #13 two times a week for one week, and then one time a week for two weeks. The clinical record lacked documented evidence the physician was made aware of the missed visits. There were no physician's orders decreasing the visits for PT. Patient #15 Patient #15 was admitted on 3/22/09 with diagnoses including gouty arthropathy, mononeuritis of the leg, non-insulin dependent diabetes mellitus, hypertension and chronic obstructive pulmonary disease with exacerbation. The Plan of Care included orders for skilled nursing (SN) to see Patient #15 two times a week for two weeks and then, one time a week for	G 158		

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G 158	Continued From page 25 seven weeks. Patient #15's clinical record lacked documented evidence of a visit being made during the eighth week. There was no documented evidence in Patient #15's clinical record to indicate the physician was notified that a visit was not made during the week of 6/21/09. The clinical record lacked a physician's order to decrease the visits the week of 6/21/09. Patient #16 Patient #16 was admitted on 9/4/08 with diagnoses including debility, chronic obstructive asthma, hypertension, congestive heart failure and cancer of the vulva. Patient #16's Plan of Care (POC) included orders to weigh the patient every week. The skilled nursing visit notes (SNVN) for 5/1/09, 5/8/09 and 5/18/09 lacked documented evidence Patient #16 was weighed on those three dates. Patient #16's POC included orders for a certified nursing assistant (CNA) "2X9" (two times a week for nine weeks) to assist with personal care and activities of daily living. The first week of Patient #16's certification was two days long (Friday and Saturday). The clinical record lacked CNA notes for these two days. There was no physician's order to decrease the CNA visits for the first week of the certification period. Review of the policy regarding the Plan of Care,	G 158		

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G 158	Continued From page 26 revealed "... First Choice Home Health Care, LLC staff members promptly inform the physician of any changes that suggest a need to alter the client plan of care..." On 7/7/09 in the afternoon, the director of nursing acknowledged some instruction needs to be done so all staff will understand their roles and the need to communicate with one another to ensure physician's orders are followed. Note: The agency's week was from Sunday to Saturday.	G 158		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on interview, record review and document review, the agency failed to ensure 1) medications and treatments were administered, and 2) visits were made only as ordered by the physician for 8 of 15 patients (Patients #1, 3, 4, 6, 7, 10, 11, 13). Findings include: Patient #1 Patient #1 was admitted on 7/9/08 with diagnoses including paraplegia, neurogenic bowel, constipation and hypertension. The Plan of Care (POC) indicated Patient #1 was to be seen by the certified nursing assistant five times a week for nine weeks.	G 165		

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G 165	Continued From page 27 Documentation in the clinical record revealed Patient #1 was seen six times during the week of 5/10/09. The clinical record lacked documented evidence the physician was notified of the need for an additional visit. The clinical record lacked documented evidence of a physician's order to increase the number of visits for the week of 6/7/09. The certified nursing assistant (CNA) Plan of Care for Patient #1 indicated the CNA was to see the patient five times a week for nine weeks for personal care, hygiene and assistance with personal activities of daily living. The CNA assignment prepared by the registered nurse (RN) did not include skin/foot care, grocery shopping, washing clothes and light housekeeping. Out of 30 visit notes, documentation in Patient #1's clinical record revealed the CNA provided skin and foot care 30 times, went grocery shopping eight times, washed clothing 18 times and performed light housekeeping 30 times. There was no documented evidence in Patient #1's clinical record indicating the CNA had contacted the primary nurse on the case to request the four activities listed above be added to the CNA care plan. The clinical record lacked documented evidence the RN followed up with the CNA to see if additional tasks needed to be added to Patient #1's care plan.	G 165		

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G 165	Continued From page 28 In an interview on 7/1/09 in the morning, regarding the extra tasks the CNA did for Patient #1, the CNA explained, "The patient needs it so I just do it." Patient #3 Patient #3 was admitted on 6/2/09 with diagnoses including pressure ulcer left foot, hypertension, senile dementia and anxiety disorder. The patient was living in an assisted living facility. On 6/8/09, the RN managing Patient #3's case wrote a physician's order that read, "Wound care: once a week. SN to cleanse the wound with NSS (normal saline solution). Pat dry. Apply Hydrogel with Tegaderm. Cover area with DSD (dry sterile dressing) and secure with tape." Documentation in the clinical record included skilled nurse visit notes dated 6/8/09, 6/9/09, 6/13/09, 6/15/09, 6/18/09, 6/19/09, 6/22/09 and 6/24/09 which all indicated the LPN "Removed Duoderm, cleansed with NS 0.9%, pat dry with 4X4 gauze, apply Duoderm." During a joint visit on 7/1/09 in the afternoon, Employee #5 cleansed the wound with normal saline, wiped it with a dry gauze and then applied Duoderm to cover the affected area. Patient #4 Patient #4 was admitted on 4/16/09 with diagnoses including abnormality of gait, hypertension, congestive heart failure and osteoarthritis of the pelvis. The original skilled nursing (SN) frequency	G 165		

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ordered was three times a week for one week; two times a week for two weeks; and then, one time a week for six weeks.

On 5/7/09, a physician's order was written for SN to see Patient #4 every other day for a week. There was no order for SN after the week of every other day visits was completed.

According to the skilled nursing visit notes in the clinical record, the licensed practical nurse saw Patient #4 once a week for three weeks with no physician's orders to do so.

Patient #6

Patient #6 was admitted on 2/18/08 with diagnoses including generalized muscle weakness, abnormality of gait, hypertension and long-term use of anticoagulant.

Beginning the week of 3/1/09, Patient #6 had a physician's order to be seen by the certified nursing assistant (CNA) two times a week for five weeks. The clinical record contained three CNA notes for the week of 3/1/09.

Patient #7

Patient #7 was admitted on 5/4/09 with diagnoses including peripheral vascular disease, peripheral neuropathy, gout and hypertension.

On 5/12/09, Patient #7 was admitted to an acute care facility secondary to a nosebleed.

On 5/19/09, skilled nursing (SN) did a resumption of care visit. The physician's order indicated SN frequency from 5/19/09 was to be two times a

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week for three weeks and then, one time a week for four weeks.

The clinical record contained two SN visit notes dated 6/15/09 and 6/16/09 during the seventh week of the nine week certification period. There was no physician's order in Patient #7's clinical record for an additional visit during the seventh week.

Patient #10

Patient #10 was admitted on 4/27/09 with diagnoses including pressure ulcer, non-insulin dependent diabetes mellitus, hypertension, senile dementia and failure to thrive.

Patient #10 had a peripherally inserted central catheter (PICC) for administration of intravenous antibiotics.

The Plan of Care (POC) lacked orders for Patient #10's PICC site dressing to be changed. There were no supplemental orders in the clinical record for the nurse to change the PICC site dressing.

Documentation on clinical notes revealed the nurse changed Patient #10's PICC site dressing on 5/1/09, 6/6/09 and 6/9/09.

Patient #10's POC lacked orders specifying the amount of Normal Saline (NS) and the amount and concentration of Heparin with which the PICC was to be flushed before and after antibiotic administration. NS and Heparin were not listed in the Medication Section of the POC or on the Medication Profile.

Patient #11

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Patient #11 was admitted on 6/22/09 with diagnoses including insulin dependent diabetes mellitus, abnormality of gait, hypertension, lumbago and end stage renal disease.

Patient #11 had physician's orders for skilled nursing (SN) to visit twice a day.

According to documentation in Patient #11's clinical record, SN saw the patient three times on 6/28/09. The clinical record lacked a physician's order for the third visit on 6/28/09.

Patient #11's clinical record included a physician's order, dated 6/3/09 which read, "CNA (certified nursing assistant) visits to start on week of June 14 per family request." The order did not include the frequency and duration of the CNA visits.

The CNA saw Patient #11 two times a week for two weeks.

Patient #13

Patient #13 was admitted on 1/30/09 with diagnoses including insulin dependent diabetes mellitus, neuropathy, hemiplegia, chronic pain and general osteoarthrosis.

Patient #13's clinical record included a physician's order dated 6/3/09 which read, "Ok for PT (physical therapy) to see pt (patient) next week."

Physical therapy visit notes in the clinical record revealed PT saw Patient #13 on 6/3/09 and 6/6/09.

On 6/29/09, the licensed practical nurse (LPN)

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G 165	Continued From page 32 documented Patient #13 was taking Glipizide 5 milligrams by mouth a day. Patient #13's clinical record had no physician's order for Glipizide. Glipizide was not listed on the Plan of Care. Glipizide was not listed on the Medication Profile. The agency's policy Orders for Medications and Treatment (date effective, revised and approved blank), indicated "... a) No medication or treatment shall be given except on signed order of a person lawfully authorized to give such order may be given by telephone and shall signed by the client's attending physician, dentist or podiatrist or other legally authorized practitioner within his and her scope of practice ... g) Medications and treatments shall be administered as prescribed and shall be recorded in client's health record, as administered."	G 165		
G 172	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. This STANDARD is not met as evidenced by: Based on record review and document review, the agency failed to ensure the registered nurse regularly re-evaluated the needs for 7 of 17 patients (Patient #3, 4, 5, 6, 7, 9, 13). Findings include: Patient #3 Patient #3 was admitted on 6/2/09 with diagnoses including pressure ulcer on the left foot,	G 172		

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hypertension, senile dementia and anxiety disorder.

A registered nurse (RN) saw Patient #3 the first two times. The LPN saw the patient nine consecutive times over the next four weeks.

According to the agency's policy and procedure regarding wound assessment and documentation, "... For consistent evaluation, it is advisable for the case manager (registered nurse) to measure/stage the wound the first visit each week ..."

Patient #4

Patient #4 was admitted on 4/16/09 with diagnoses including abnormality of gait, hypertension, congestive heart failure and osteoarthritis of the pelvis.

The licensed practical nurse saw Patient #4 fourteen consecutive times over seven weeks.

Patient #5

Patient #5 was admitted on 10/17/08 with diagnoses including paralysis agitans, non-insulin dependent diabetes mellitus, hypertension and osteoporosis.

The licensed practical nurse saw Patient #5 nine times over eight weeks. The registered nurse did not see the patient until the recertification visit on 6/13/09.

Patient #6

Patient #6 was admitted on 2/18/08 with

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G 172	Continued From page 34 diagnoses including generalized muscle weakness, abnormality of gait, hypertension and long-term use of anticoagulant. The registered nurse performed a resumption of care for Patient #6 on 1/11/09 after a four day admission in an acute care facility. The licensed practical nurse saw Patient #6 eight consecutive times over the next six weeks. On 3/30/09, Patient #6 was readmitted to an acute care facility. Patient #7 Patient #7 was admitted on 5/4/09 with diagnoses including peripheral vascular disease, peripheral neuropathy, gout and hypertension. After the registered nurse admitted Patient #7, a licensed practical nurse saw the patient three times. On 5/12/09, Patient #7 was readmitted to an acute care facility, reason unknown. On 5/19/09, the registered nurse did a resumption of care visit. Following the resumption of care visit, the licensed practical nurse saw Patient #7 eight consecutive times over six weeks. Patient #9 Patient #9 was admitted on 2/23/09 with diagnoses including generalized muscle weakness, lumbago, osteoarthrosis, abnormality of gait and coronary artery disease.	G 172		

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After the registered nurse completed Patient #9's recertification visit on 4/19/09, the licensed practical nurse saw the patient six consecutive times over the next six weeks.

The clinical record lacked documentation of a skilled nursing visit during the seventh and eight week of the certification period. On the second day of the eighth week, Patient #9 was transported to an acute care facility secondary to a fall.

Patient #13

Patient #13 was admitted on 1/30/09 with diagnoses including insulin dependent diabetes mellitus, neuropathy, hemiplegia, chronic pain and general osteoarthrosis.

The registered nurse completed a recertification visit on 5/29/09 for the certification period of 5/30/09 through 7/28/09. The licensed practical nurse (LPN) saw Patient #13 for 38 consecutive visits over 31 days.

According to the documentation on the supervisory note dated 6/29/09, the registered nurse did an off-site supervisory visit. The registered nurse did not see the patient to re-evaluate their needs for four weeks.

The agency's policy Licensed Vocational (Practical) Nurse Supervision, effective, revised and approved date 9/16/06, revealed "... If the Registered Nurse is alternating skilled visits with the Licensed Vocational Nurse, supervisory visits do not need to be joint visits, but a joint visit with the Licensed Vocational Nurse will be completed at least monthly ..."

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G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure the registered nurse prepared complete and accurate documentation reflecting the care provided for 3 of 17 patients (Patients #8, 10, 17). Findings include: Patient #8 Patient #8 was admitted on 5/18/09 with diagnoses including generalized muscle weakness, pulmonary embolism, debility, hypertension and general osteoarthrosis. Patient #8's clinical record included a physician's order dated 5/28/09 to "... repeat PT/INR tomorrow." The Skilled Nursing Visit Note dated 5/29/09 and signed by the RN, lacked documented evidence blood was drawn from Patient #8 and delivered to a lab. Patient #10 Patient #10 was admitted on 4/27/09 with diagnoses including pressure ulcer, non-insulin dependent diabetes mellitus, hypertension, senile dementia and failure to thrive.	G 176		

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G 176	Continued From page 37 Patient #10 had a peripherally inserted central catheter (PICC) for administration of intravenous (IV) antibiotics. There were no orders in the Plan of Care (POC) for Patient #10's PICC dressing to be changed. There were no supplemental orders in the clinical record to change the PICC site dressing and how often. Documentation on the Skilled Nursing Visit Notes (SNVN) dated 5/1/09, 6/6/09 and 6/9/09, revealed the registered nurse (RN) changed Patient #10's PICC site dressing. The POC had orders that read " Using aseptic technique, flush line with 3 - 5 cc (cubic centimeters) of NS (Normal Saline) prior to administration, administer IV medication Cefepime slowly over 3 mins (minutes), then flush with 3 - 5 cc NS and Heparin lock solution. " The amount and concentration of Heparin to be used for flushing the PICC line were not listed on Patient #10 ' s Plan of Care, Medication Profile or supplemental physician's orders. SNVNs dated 4/29/09, 4/30/09, 5/2/09 and signed by the RN, lacked documented evidence indicating the IV antibiotic was administered to Patient #10 on those dates. Patient #10's clinical record included a SNVN dated 5/1/09 and signed by the RN which read, " Antibiotics given via PICC line. Flushed with 10 U (units) of NS (normal saline) Dsg (dressing changed). " The RN failed to document the name and dose of	G 176		

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the antibiotic, the specifics of the flushes administered and how Patient #10 tolerated the infusion. The RN failed to document the technique used, status of the line and how Patient #10 tolerated the PICC site dressing change.

The SNVN dated 5/3/09 and signed by the RN, did not include the name of the antibiotic, the dose, the specifics of the flushes administered and how Patient #10 tolerated the procedure.

Patient #17

Patient #17 was admitted on 1/2/08 with diagnoses including congestive heart failure, dementia and anemia.

Patient #17's clinical record included a communication note dated 1/18/08 wherein the RN documented her conversation with the medical social worker (MSW). The RN indicated the patient was not taking medications as prescribed secondary to dementia. The RN told the MSW the patient was not safe to be living by herself and needed 24 hour supervision.

The RN documented a call was made to Patient #17's primary care physician. The physician was not available and a message was left. There was no documentation in the clinical record indicating the RN followed up and advised the physician the patient's living situation was unsafe.

The agency's policy Significant Change of Condition for MD Notification (effective, revised and approved date blank), revealed "... 1. Employees or contract employees providing direct patient care perform a physical, psychosocial and environment assessment during each visit. Any

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G 176	Continued From page 39 significant changes observed or reported to the physician as appropriate. These include: A. Unsafe home situation...."	G 176		
G 178	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse participates in in-service programs, and supervises and teaches other nursing personnel. This STANDARD is not met as evidenced by: Based on interview, record review and document review, the agency failed to ensure the licensed practical nurse was supervised by the registered nurse on a continuing, regular basis for 6 of 17 patients (Patients #4, 5, 6, 7, 9, 11). Findings include: Patient #4 Patient #4 was admitted on 4/16/09 with diagnoses including abnormality of gait, hypertension, congestive heart failure and osteoarthritis of the pelvis. Documentation in the clinical record revealed the licensed practical nurse saw Patient #4 a total of 14 times over seven weeks with no supervisory visit by the registered nurse. Patient #5 Patient #5 was admitted on 10/17/08 with diagnoses including paralysis agitans, non-insulin dependent diabetes mellitus, hypertension and osteoporosis.	G 178		

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Documentation in the clinical record revealed the licensed practical nurse saw Patient #5 a total of nine times over eight weeks with no supervisory visit by the registered nurse.

Patient #6

Patient #6 was admitted on 2/18/08 with diagnoses including generalized muscle weakness, abnormality of gait, hypertension and long-term use of anticoagulant.

Documentation in the clinical record revealed the licensed practical nurse saw Patient #6 a total of 8 times over five weeks with no supervisory visit by the registered nurse.

Patient #7

Patient #7 was admitted on 5/4/09 with diagnoses including peripheral vascular disease, peripheral neuropathy, gout and hypertension.

Documentation in the clinical record revealed the licensed practical nurse saw Patient #7 a total of 8 times over five weeks with no supervisory visit by the registered nurse during that time.

Patient #9

Patient #9 was admitted on 2/23/09 with diagnoses including generalized muscle weakness, lumbago, osteoarthrosis, abnormality of gait and coronary artery disease.

Patient #9 was seen by the licensed practical nurse a total of nine times over a six week period with no supervisory visit by the registered nurse during that time.

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G 178	Continued From page 41 Patient #11 Patient #11 was admitted on 6/22/09 with diagnoses including insulin dependent diabetes mellitus, abnormality of gait, hypertension, lumbago and end stage renal disease. The registered nurse (RN) saw Patient #11 for the start of care and comprehensive assessment. The licensed practical nurse (LPN) saw the patient twice a day for 21 days and three times a day for one day. The LPN saw Patient #11 a total of 47 times over a five week period with no supervisory visit by the registered nurse during that time. On 6/30/09 at 10:45 AM, the director of nursing indicated the LPN supervisory visits are done "every time a re-certification is done every 60 - 62 days." According to the agency's policy, Licensed Vocational Nurse Supervision, effective 9/16/06, "... a joint visit with the Licensed Vocational Nurse will be completed at least monthly ..."	G 178		
G 180	484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse prepares clinical and progress notes. This STANDARD is not met as evidenced by: Based on record review and document review, the agency failed to ensure the licensed practical nurse prepared complete and accurate	G 180		

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G 180	Continued From page 42 documentation reflecting the care provided for 3 of 17 patients (Patients #6, 7, 8). Findings include: Patient #6 Patient #6 was admitted on 2/18/08 with diagnoses including generalized muscle weakness, abnormality of gait, hypertension and long-term use of anticoagulant. The second page of a skilled nursing visit note (SNVN) dated 2/12/09 revealed the licensed practical nurse (LPN) checked the box "cleanse" under treatment. The LPN did not indicate what solution the wound was cleaned with. Patient #7 Patient #7 was admitted on 5/4/09 with diagnoses including peripheral vascular disease, peripheral neuropathy, gout and hypertension. On 5/7/09, the director of nursing (DON) received a physician's order to have skilled nursing (SN) see Patient #7 on 5/8/09 to draw blood for a lab test (PT/INR). The clinical record contained a note which was signed by the licensed practical nurse (LPN) and dated 5/8/09. There was no documentation regarding a blood draw, how Patient #7 tolerated the procedure, to which lab the specimen was delivered, etc. The clinical record contained a note which was signed by the licensed practical nurse (LPN) and	G 180		

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G 180	Continued From page 43 dated 5/12/09. The LPN documented "PT/INR drawn today." There was no documentation regarding size and type of blood draw supplies used , how Patient #7 tolerated the procedure, to which lab the specimen was delivered, etc. The clinical record contained a note which was signed by the licensed practical nurse (LPN) and dated 6/12. The LPN documented "PT/INR drawn today." There was no documentation regarding size and type of blood draw supplies used, how Patient #7 tolerated the procedure, to which lab the specimen was delivered, etc. The clinical record contained a note which was signed by the licensed practical nurse (LPN) and dated 6/23/09. There was no documentation regarding size and type of blood draw supplies used, how Patient #7 tolerated the procedure, to which lab the specimen was delivered , etc. Patient #7's name and signature were on the Weekly Route Sheet and Patient Acknowledgement and Staff Certification of Services Rendered form. In the right hand column of the form, the LPN documented, "PT/INR drawn today." Patient #8 Patient #8 was admitted on 5/18/09 with diagnoses including generalized muscle weakness, pulmonary embolism, debility, hypertension and general osteoarthrosis. The clinical record contained a note signed by the licensed practical nurse (LPN) and dated 5/21/09. The LPN documented "Blood sample collected for PT/INR. Sample sent to (name of) lab." There	G 180		

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G 180	Continued From page 44 was no documentation regarding size and type of blood draw supplies used, how Patient #8 tolerated the procedure, etc. Patient #8's clinical record contained a physicians's order for a " ... repeat PT with INR on Tuesday 5/26/09." The clinical record contained a note which was signed by the licensed practical nurse (LPN) and dated 5/26/09. There was no documentation on the visit note regarding a blood draw. The agency's policy, Skilled Nursing Services, revealed "... 3. The duties of the home health care licensed practical nurse (LPN) include the following: ... b. preparing client clinical and progress notes..."	G 180		
G 224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure the registered nurse prepared a completed care plan to be used by the certified nursing assistant while caring for 5 of 15 patients (Patients #1, 6, 11, 16, 17). Findings include: Patient #1	G 224		

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Continued From page 45

Patient #1 was admitted on 7/9/08 with diagnoses including paraplegia, neurogenic bowel, constipation and hypertension.

The Plan of Care for Patient #1 included orders for the certified nursing assistant (CNA) to see the patient five times a week for nine weeks for personal care, hygiene and assistance with personal activities of daily living.

Patient #1's CNA assignment prepared by the registered nurse (RN) did not include skin/foot care, grocery shopping, washing clothes and light housekeeping.

Documentation on 30 visit notes for Patient #1 revealed the CNA provided skin and foot care 30 times; went grocery shopping eight times; washed the patient's clothing 18 times and performed light housekeeping 30 times.

There was no documented evidence in Patient #1's clinical record indicating the CNA contacted the primary nurse on the case to request the four activities above be added to the CNA care plan.

In an interview on 7/1/09 in the morning, the CNA explained, "The patient (#1) needs it so I just do it."

Patient #6

Patient #6 was admitted on 2/18/08 with diagnoses including generalized muscle weakness, abnormality of gait, hypertension and long-term use of anticoagulant.

Patient #6 had a certified nursing assistant (CNA)

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to assist with personal care and activities of daily living.

The registered nurse (RN) prepared a Certified Nursing Assistant Assignment. The Assignment included "tub/shower, bed bath - P/C and assist bath-chair" There was no documentation indicating when or why one method should be used as an alternate method for bathing Patient #6.

The CNA Assignment had an area marked, "BP (blood pressure) sit/lying/stand." There was no documentation to indicate what position Patient #6 should be in when having their blood pressure measured.

The CNA Assignment had an area that read, "Inc. (increase)/Des. (decrease) fluid. The RN placed a check mark in the area next to this assignment. There was no documentation indicating if the CNA was to increase or decrease fluid intake for Patient #6.

There was no documented evidence in Patient #6's clinical record indicating the CNA contacted the primary nurse on the case for clarification of the CNA care plan.

Patient #11

Patient #11 was admitted on 6/22/09 with diagnoses including insulin dependent diabetes mellitus, abnormality of gait, hypertension, lumbago and end stage renal disease.

The RN prepared a Certified Nursing Assistant Assignment for Patient #11. The area marked "Activities" and consisting of "bed bath - p/c

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G 224	Continued From page 47 (partial/complete), assist bath-chair, pressure area, oral care, dressing inspect/reinforce and transfers" were not marked by the RN to indicate the CNA was supposed to perform them. The clinical record for Patient #11 included CNA visit notes dated 6/18/09, 6/20/09, 6/21/09 and 6/26/09. These notes included documentation indicating the CNA had given Patient #11 a bed bath (partial/complete not noted), assisted with bath-chair, (checked?) pressure area, assisted with oral care, inspected/reinforced dressing (location unknown) and assisted with transfers. There was no documentation in Patient #11's clinical record indicating the CNA contacted the RN to clarify the tasks assigned and ask for additional tasks to be included in the assignment. Patient #16 Patient #16 was admitted on 9/4/08 with diagnoses including debility, chronic obstructive asthma, hypertension, vulvar cancer and congestive heart failure. The Plan of Care for Patient #16 called for the certified nursing assistant (CNA) to see the patient two times a week for nine weeks for personal care, hygiene and assistance with personal activities of daily living. The registered nurse (RN) prepared a Certified Nursing Assistant Assignment for Patient #16. The Assignment included "tub/shower and assist bath-chair." There was no documentation indicating when or why one method should be used as an alternate method for bathing the patient.	G 224		

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G 224	Continued From page 48 In the blood pressure section of the assignment sheet, the RN did not specify if Patient #16 should lie down, sit or stand for the reading. The clinical record for Patient #16 included CNA notes for eight weeks (two visits per week). These notes included documentation indicating the CNA had given Patient #16 a tub bath, assisted with bath - chair and assisted with transfers and ambulation. There was no documentation in Patient #16's clinical record indicating the CNA contacted the RN for clarification of the tasks assigned. Patient #17 Patient #17 was admitted on 1/2/08 with diagnoses including congestive heart failure, dementia and anemia. The registered nurse (RN) prepared a Certified Nursing Assistant (CNA) Assignment for Patient #17. The Assignment included "tub/shower and assist bath-chair." There was no documentation indicating when or why one method should be used as an alternate method for bathing the patient. On all CNA visit notes, with the exception of two dated 2/6/09 and 2/8/09, the CNA indicated that both methods of bathing were used. The RN wrote for the CNA to document when Patient #17's last bowel movement was. This section was left blank on all 17 CNA notes. The RN did not specify if Patient #17 should lie	G 224		

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G 224	Continued From page 49 down, sit or stand for the reading. There was no documentation in Patient #17's clinical record indicating the CNA contacted the RN for clarification of the tasks assigned.	G 224		
G 229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. This STANDARD is not met as evidenced by: Based on record review and document review, the agency failed to ensure certified nursing assistants were supervised during an on-site visit by the registered nurse at least every 14 days for 4 of 17 patients (Patients #1, 6, 16, 17). Findings include: Patient #1 Patient #1 was admitted on 7/9/08 with diagnoses including paraplegia, neurogenic bowel, constipation and hypertension. The registered nurse (RN) was seeing Patient #1 twice a week. The CNA was seeing the patient five times a week. The clinical record for Patient #1 lacked documented evidence of a CNA supervisory visit by the RN for the certification period of 5/5/09 through 7/3/09. Patient #6	G 229		

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Patient #6 was admitted on 2/18/08 with diagnoses including generalized muscle weakness, abnormality of gait, hypertension and long-term use of anticoagulant.

The registered nurse (RN) performed a supervisory visit with the CNA on 2/9/09. Patient #6's clinical record had no documented evidence of a supervisory visit of the CNA by the RN for the certification period of 2/12/09 through 4/12/09.

Patient #16

Patient #16 was admitted on 9/4/08 with diagnoses including debility, chronic obstructive asthma, hypertension, and congestive heart failure.

A certified nursing assistant (CNA) supervisory visit by the registered nurse (RN) was due for Patient #16 on 6/12/09. The next documented evidence of a CNA supervisory by the RN was dated 6/19/09.

Patient #17

Patient #17 was admitted on 1/2/08 with diagnoses including congestive heart failure, dementia and anemia.

Patient #17 had a physician's order for a certified nursing assistant (CNA) two times a week (except for the week of 1/6/09, when the frequency was increased to three times a week for that one week) for assistance with personal care and activities of daily living.

Patient #17's clinical record lacked

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G 229	Continued From page 51 documentation of a CNA supervisory visit by the RN until after the CNA had seen the patient fourteen times during a seven week period. According to the agency's policy Supervisory Visit (CNA/PTA/COTA), effective, revised and approved date blank, "...1. When a patient is receiving Skilled Nursing Care and the services of a Certified Nurse Assistant (CNA), the RN Supervisor/DPCS shall make on site supervisory visit to patient's home no less frequently than every two weeks ..."	G 229		
G 236	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. This STANDARD is not met as evidenced by: Based on record review, the agency failed to ensure pertinent medical histories were maintained in the clinical records for 1 of 17 patients (Patient #13). Findings include: Patient #13 Patient #13 was admitted on 1/30/09 with diagnoses including insulin dependent diabetes	G 236		

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G 236	Continued From page 52 mellitus, neuropathy, hemiplegia, chronic pain and general osteoarthrosis. Patient #13's clinical record did not contain any information regarding the patient's past medical history.	G 236		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on record review and document review, the agency failed to ensure a comprehensive medication assessment and subsequent update of the care plan occurred for 6 of 15 patients (Patients #1, 2, 11, 12, 13, 15). Findings include: Patient #1 Patient #1 was admitted on 7/9/08 with diagnoses including paraplegia, neurogenic bowel, constipation and hypertension. Patient #1 was recertified for the period of 5/5/09 through 7/3/09. Documentation on the Medication Profile (MP), dated 4/30/09, revealed the patient was taking Diclofenac Sodium 50 milligrams per tablet one tablet by mouth every day. The Plan of Care (POC) generated from the MP,	G 337		

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G 337	Continued From page 53 and signed by the physician, revealed the patient was to take Diclofenac Sodium 50 milligrams per tablet one tablet by mouth three times a day. The prescription label for the Diclofenac Sodium indicated Patient #1 was to take "one tablet by mouth three times a day." For the first two certification periods, the MP revealed Patient #1 was to take Lisinopril 10 milligrams per tablet one tablet by mouth every day. Lisinopril was not listed on the current MP and POC. For the first two certification periods, the MP revealed Patient #1 was to take Percocet 7.5/325 milligrams per tablet one tablet by mouth every six hours. During a home visit on 7/1/09 in the morning, Patient #1 indicated he was taking Diclofenac Sodium 50 milligrams per tablet one tablet by mouth three times a day. Patient #1 indicated he was taking Lisinopril 10 milligrams per tablet one tablet by mouth every day and has been "since two years ago." Patient #1 indicated he stopped taking Percocet "a year ago." Patient #1 had a bottle of Aspirin 325 milligrams per tablet. The patient indicated he took one a day "for thinning the blood" and "doesn't take them regularly." The MPs and POC for all three certification periods did not list Aspirin as one of the medications Patient #1 was to take.	G 337		

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G 337	Continued From page 54 Patient #2 Patient #2 was admitted on 6/10/09 with diagnoses including generalized muscle weakness, Parkinson ' s Disease, and atrial fibrillation. The Plan of Care (POC) for Patient #2 indicated the patient was taking Donepezil Hcl 10 milligrams per tablet one tablet by mouth daily. The patient indicated she stopped taking this medication "six months ago." The POC for Patient #2 indicated the patient was taking Loratadine 10 milligrams per tablet one tablet by mouth every day. The patient indicated she has been taking this only as needed for allergies since 6/09. The POC for Patient #2 indicated the patient was taking a multivitamin by mouth two times a day. The patient indicated this was discontinued after the last hospitalization. The POC for Patient #2 indicated the patient was taking Docusate 85/50 milligrams per tablet one tablet by mouth twice a day. The patient indicated she has been taking Docusate 80/50 two tablets by mouth at bedtime since being in the hospital. The POC for Patient #2 indicated the patient was taking Detrol 4 milligrams one tablet by mouth at PM. The patient indicated she had been taking Detrol 2 milligrams at bedtime since she first received it (three months ago). The POC for Patient #2 indicated the patient was taking Diovan 40 milligrams per tablet one tablet	G 337		

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by mouth every day. The patient indicated she has not taken this since her last hospitalization.

The POC for Patient #2 indicated the patient was taking Coumadin 4 milligrams per tablet one tablet by mouth every day. The patient indicated she was currently on 5 milligrams every day except Tuesdays and Fridays when she took Coumadin 7.5 milligrams.

The Medication Profile for Patient #2 did not include documentation of the current Coumadin dosing.

The POC for Patient #2 indicated the patient was taking Ativan 0.5 milligrams per tablet one tablet by mouth twice a day as needed for anxiety. The prescription label on the bottle read, "Ativan 0.5 mg (milligrams) 1 tablet by mouth every 6 hours as needed for anxiety."

Patient #2 indicated she was taking Tums 640 milligrams (calcium) two tablets a couple times a week; Tylenol 500 milligrams two tablets as needed "when Tums don't work"; Ultram 50 milligrams one tablet by mouth every four hours as needed for pain "since 1/09 hospitalization"; and Cozaar 50 milligrams per tablet one tablet by mouth twice a day "for 10 years now".

Patient #11

Patient #11 was admitted on 6/22/09 with diagnoses including insulin dependent diabetes mellitus, abnormality of gait, hypertension, lumbago and end stage renal disease.

A skilled nursing visit note (SNVN) dated 6/20/09 and signed by the licensed practical nurse (LPN)

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revealed Patient #11 "... currently on Keflex 500 mg (milligrams) PO (by mouth) x (times) 10 days for infection ..."

Patient #11's clinical record had no physician's order for Keflex. Keflex was not listed on the Plan of Care (POC). Keflex was not on the Medication Profile (MP).

A SNVN dated 6/22/09 revealed Patient #11 was taking Lortab (dosage unknown).

Patient #11's clinical record had no physician's order for Lortab. Lortab was not listed on the POC. Lortab was not on the MP.

A SNVN dated 6/22/09 and signed by the LPN revealed Patient #11 "... Remains on Demadex (Torsemide) 40 mg (milligrams) a day ..."

According to the POC and MP, Patient #11 was prescribed Torsemide 20 mg by mouth every day. The clinical record lacked a physician's order to increase the medication to 40 mg every day.

Patient #12

Patient #12 was admitted on 6/1/09 with diagnoses including lumbago, hypertension, congestive heart failure, general osteoarthrosis and generalized anxiety.

On 6/2/09, a physician's order was written for Patient #12 to "Change Acetamenophen 500 mg (milligrams) tabs (tablets) two tabs q (every) 4 - 6 hours PRN (as needed) for pain to 500 mg 1 - 2 tablets q 6 hours PRN pain."

Patient #12's Medication Profile lacked

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documented evidence of being updated with this change. There was no documentation in the clinical record to indicate the patient was made aware of the change in the medication.

Patient #13

Patient #13 was admitted on 1/30/09 with diagnoses including insulin dependent diabetes mellitus, neuropathy, hemiplegia, chronic pain and general osteoarthrosis.

According to the Recertification Order dated 5/29/09, Patient #13 was taking Gabapentin 300 mg one tab PO three times a day.

Gabapentin was not listed on Patient #13's Plan of Care for the certification period of 5/30/09 through 7/28/09. Gabapentin was not listed on the Medication Profile.

On 5/30/09, a physician's order was written for Patient #13 to take Lyrica 100 mg (milligrams) two tabs (tablets) PO (by mouth) TID (three times a day). The update on the Medication Profile read, "Lyrica 100 mg 2 tabs PO."

On 6/5/09, a physician's order was written for Patient #13 to take "Benazepril 20 mg PO 2 x (times) a day and Clonidine 0.2 mg PO now." The Medication Profile lacked documented evidence of these two medication being added.

Patient #13's clinical record included a skilled nursing visit note (SNVN) dated 6/29/09. The licensed practical nurse (LPN) documented the patient was taking Glipizide 5 milligrams a day.

Patient #13's clinical record had no physician's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297105	A. BUILDING ______ B. WING ______	07/07/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE HOME HEALTHCARE, LLC	2995 SOUTH JONES BLVD, SUITE A LAS VEGAS, NV 89146

(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
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order for Glipizide. Glipizide was not listed on the Plan of Care. Glipizide was not listed on the Medication Profile.

Patient #15

Patient #15 was admitted on 3/2/09 with diagnoses including gouty arthropathy, mononeuritis of the leg, non-insulin dependent diabetes mellitus, hypertension and chronic obstructive pulmonary disease with exacerbation.

Patient #15's Medication Profile revealed the patient was on "Oxygen at 2 - 3 liters per minute via nasal cannula continuously." Oxygen was not listed on Patient #15's Medication Profile.

The agency's policy, Medication Profile, (date effective, revised and approved all blank), revealed "I. POLICY It is the Policy of First Choice Home Health Care, LLC (FC HHC, LLC) that all patient medications (prescription and OTC (over the counter)) medication will be documented on the medication profile. The medication profile will be updated on an ongoing basis ... A. Updating of the medication profile is done on an ongoing basis. 1. ...Medication profile is updated in the medical record every re-certification and whenever there are changes in medication ... 4. QA (quality assurance) will monitor medical record to ensure medication profile is updated with changes in medication ..."