Example 1 G202 Home Health Aide Services

NAME OF PROVIDER OR SUPPLIER:

(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	(X5) COMPLETION DATE
G 202	HOME HEALTH AIDE SERVICES This CONDITION is not met as evidenced by clinical record review revealing significant issues with: - development of an appropriate, clear aide plan of care (G224) -aides not following the aide plans of care (G225) -noncompliance with the CMS requirement for Home Health Aide supervision, on-site, every two weeks/14 days.(G229) The cumulative effect of these findings indicates a lack of adequate oversight of Home Health Aides, and could negatively impact the provision of safe quality care.	G 202	The Director of Nursing will hold a staff meeting with the Registered Nurses on their responsibility to develop and appropriate Home Health Aide Care Plan and will specifically address the ordering of bathing activities and the expected frequency of tasks to be performed and that the use of PRN on the aide assignment is not allowed. The DON will also address the responsibility of the RN to perform a aide supervisory visit at least every 14 day which is to include an assessment of compliance to the Aide Care Plan. Development of the Aide Care Plan and Aide supervision responsibility is included on the orientation plan/checklist. The DON will hold a staff meeting with the Home Health Aides on following of the Home Health Aide Care Plan developed by the RN and on how to report to the RN changes in the patient's condition. The DON will arrange for an review by clinical staff of all current clinical records with aide service to assure that the aide care plan is appropriate, that the RNs are conducting the required aide supervisory visits and that the Home Health Aide is following the written instructions provided. The DON or designee will review 100% of all records until 95% compliance attained then 10% or at least 5 applicable records will be reviewed twice month until 90% is achieved and then quarterly to maintain compliance within 90%. Staff retraining and increased record reviews will occur as needed to restore compliance if the compliance falls below the compliance expectation. Staff retraining and/or disciplinary actions will be taken by DON where needed. The Director of Nursing is ultimately responsible for the plan of corrections.	2/28/14

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 was not met as evidenced by a review of medical records reveals in 9 of 9 (100%) of records the RN does not provide specific direction to the aide regarding the type of services to be provided. This deficient practice has the potential to affect all patients receiving services from the agency. **Findings are:** Record #1: aide POC indicates partial bath & shower. There is no guidance regarding the specific type of bath to be provided. The shower was D/C'd on 11/26. The POC of 11/26 indicates partial bath PRN & bed bath M-W-F. Record #2: aide POC started on 5/2, does not list frequencies for tasks the aide is to perform. In addition on 11/27 partial bath was added & the bed bath started on 5/2 was not discontinued. There is no guidance from the RN as to when to perform which type of bath, leaving it to the aide to make a determination that is out of the aide scope of practice. an appropriate, clear aide plan of care and aides not following the aide plans of care. *(Additional similar examples were attached for Records # 3, 5,7, 8, 9, 10 and 11)* Interview with Director of Nursing on 12/27/2013 at approximately 3:00 PM: Acknowledged and agreed with findings and could provide no additional documentation..	G 224	The Director of Nursing will hold a staff meeting with the Registered Nurses on their responsibility to develop and appropriate Home Health Aide Care Plan and will specifically address the ordering of bathing activities and the expected frequency of tasks to be performed and that PRN on the aide assignment is not allowed. Development of the Aide Care Plan is included on the orientation plan/checklist. The DON will hold a staff meeting with the Home Health Aides on following of the Home Health Aide Care Plan developed by the RN and on how to report to the RN changes in the patient's condition. The DON will arrange for an review by clinical staff of all current clinical records with aide service to assure that the aide care plan developed by the RN is appropriate. The DON or designee will review 100% of all records until 95% compliance attained then 10% or at least 5 applicable records will be reviewed twice month until 90% is achieved and then quarterly to maintain compliance within 90%. Staff retraining and increased record reviews will occur as needed to restore compliance if the compliance falls below the compliance expectation. Staff retraining and/or disciplinary actions will be taken by DON where needed. The Director of Nursing is ultimately responsible for the plan of corrections.	2/28/14

G 225	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. This STANDARD is not met as evidenced by a review of medical records. 2 of 10 (20%) records revealed the aide did not perform the duties as per the aide assignment. Additionally, 3 of 10 (30%) records revealed the aide did not follow the frequency on the plan of care. This deficient practice has the potential to affect all patient's served by the agency with aide services. **Findings are:** Record #5: aide documented shower every visit; the aide assignment indicates to provide a shower M-W-F only. Additionally, Record #7: 10/17/2013 - 1 Extra Visit was provided. (Additional similar examples were attached for Record #3,8 and 9) Interview with Director of Nursing on 12/27/2013 at approximately 3:00 PM: Acknowledged and agreed with findings and could provide no additional documentation..	G 225	The Director of Nursing will hold a staff meeting with the Registered Nurses on their responsibility to develop and appropriate Home Health Aide Care Plan. Development of the Aide Care Plan is included on the orientation plan/ checklist. The DON will hold a staff meeting with the Home Health Aides on following of the Home Health Aide Care Plan developed by the RN and on how to report to the RN changes in the patient's condition. The DON will arrange for an review by clinical staff of all current clinical records with aide service to assure that the aide care plan is appropriate, and that the Home Health Aide is following the written instructions provided. The DON or designee will review 100% of all records until 95% compliance attained then 10% or at least 5 applicable records will be reviewed twice month until 90% is achieved and then quarterly to maintain compliance within 90%. Staff retraining and increased record reviews will occur as needed to restore compliance if the compliance falls below the compliance expectation. Staff retraining and/or disciplinary actions will be taken by DON where needed. The Director of Nursing is ultimately responsible for the plan of corrections.	2/28/14

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: review of medical records revealing a lack of an on-site aide supervisory visit at least every 14 days in 3 of 11 (27%) records. The deficient practice has potential to affect all patients receiving services from this agency. **Findings are:** Record #3,- No supervisory visit found between 11/1/13 and 11/21/13. *(Additional similar examples were attached for Record #5 and 7)* Interview with Director of Nursing on 12/27/2013 at approximately 3:00 PM: Acknowledged and agreed with findings and could provide no additional documentation.	G 229	The Director of Nursing will hold a staff meeting with the Registered Nurses on the responsibility of the RN to perform a aide supervisory visit at least every 14 day which is to include an assessment of compliance to the Aide Care Plan. Aide supervision responsibility is included on the orientation plan/checklist. The DON will arrange for an review by clinical staff of all current clinical records with aide service to assure that the RNs are conducting the required aide supervisory visits and that the Home Health Aide is following the written instructions provided. The DON or designee will review 100% of all records until 95% compliance attained then 10% or at least 5 applicable records will be reviewed twice month until 90% is achieved and then quarterly to maintain compliance within 90%. Staff retraining and increased record reviews will occur as needed to restore compliance if the compliance falls below the compliance expectation. Staff retraining and/or disciplinary actions will be taken by DON where needed. The Director of Nursing is ultimately responsible for the plan of corrections.	2/28/14

Example 1 G156 ACCEPTANCE OF PATIENTS, POC, MED SUPER

NAME OF PROVIDER OR SUPPLIER:

(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	(X5) COMPLETION DATE
G 156	ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on clinical record review, home visit observation, and staff interview it was determined that the agency failed to meet the requirements for the Condition of Participation: Acceptance of Patients, Plan of Care, and Medical Supervision when the agency failed to: -- Assure staff followed the written plan of care as ordered by the physician (G158) -- Assure development of a complete and accurate plan of care for each patient receiving home health services (G159) -- Assure agency staff promptly alerted the physician to any changes that suggest a need to alter the plan of care (G164) The cumulative effect of these systemic practices resulted in the agency ' s inability to ensure that the patient ' s health care needs would be met by the home health agency.	G 156	The Agency Director (AD) and Director of Patient Services(DPS) met to review the organization policy and procedures related to the development of the plan of care, following the plan of care and the need for staff to alert the physician to any changes that suggest a need to alter the plan of care. No revisions were necessary. The Nursing Supervisors contacted the physicians to report the missed visits and any need to adjust the plan of care for the patient cases cited. The DPS and Nursing Supervisors reviewed their current caseload to determine if additional patients may have the same issues. The AD and DPS have begun to meet with the visiting staff, employees and contractors. Two meetings with contract therapists and 2 meetings with nursing staff will occur by 2/24/14. The meetings have/will address all aspects of their responsibilities related to the following the plan of care including frequency and duration, ordered interventions, medications and the need to contact the physician to alter the plan when needed. The DPS or designees will review 100% of all applicable records related to the plan of care until 95% compliance attained then 10% or at least 5 applicable records will be reviewed quarterly to maintain compliance within 90%. Staff retraining and increased record reviews will occur as needed to restore compliance if the compliance falls below the compliance expectation. The AD and DPS will institute staff discipline if needed. The AD and DPS will present the record review findings to the Performance Improvement and Advisory Groups for review and action. Results of PI will be presented to the Governing Body for review and action.	3/1/14

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 clinical record review and staff interview the agency failed to provide care as ordered by the physician on the plan of care or changes to the plan of care per interim physician orders in, but not limited to four of twelve records (Records #2, #5, #7, and #11). This deficient practice has the potential to affect all patients receiving services from the agency. **Findings are:** Record #2: The certification plan of care established on 10/21/13 included physician's orders for the skilled nurse to visit the patient two times weekly to instruct on medications, assess/instruct on disease process and perform wound care and instruct the caregiver to provide the wound care when the skilled nurse not present. The skilled nurse failed to document instruction of the wound care orders or observation of the caregiver providing wound care on any visit. Interview with agency director on 01/22/14 at approximately 3:00 PM: Acknowledged and agreed with findings and could provide no additional documentation.. *(Additional similar examples were attached for Record #5,7 and 11)*	G 158	The Agency Director (AD) and Director of Patient Services(DPS) met to review the organization policy and procedures related to the development of the plan of care, following the plan of care and the need for staff to alert the physician to any changes that suggest a need to alter the plan of care. No revisions were necessary. The Nursing Supervisors contacted the physicians to report the missed visits and performed ordered additional visits the week of 1/27/14 where ordered. The DPS and Nursing Supervisors reviewed their current caseload to determine if additional patients may have the same issues. Missed visits were found in 2 additional cases and the physicians were contacted and additional visits were provided for the two patients. The AD and DPS have begun to meet with the visiting staff, employees and contractors. Two meetings with contract therapists and 2 meetings with nursing staff will occur by 2/24/14. The meetings have/will address all aspects of their responsibilities related to the following the plan of care including frequency and duration, ordered interventions, medications and the need to contact the physician to alter the plan when needed. The DPS or designees will review 100% of all applicable records related to the plan of care until 95% compliance attained then 10% or at least 5 applicable records will be reviewed quarterly to maintain compliance within 90%. Staff retraining and increased record reviews will occur as needed to restore compliance if the compliance falls below the compliance expectation. The AD and DPS will institute staff discipline if needed. The AD and DPS will present the record review findings to the Performance Improvement and Advisory Groups for review and action. Results of PI will be presented to the Governing Body for review and action. The Agency Director is ultimately responsible for the plan of correction.	3/1/14

G 159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on review of clinical records the agency failed to assure the plan of care included all appropriate items when in, but not limited to, four of twelve records (Records #2, #4, #7, and #12), the plan of care or interim order updates to the plan of care did not include accurate and/or complete orders for modalities, frequency of visits, treatments, or medications. This deficient practice has the potential to affect all patient's served by the agency. Record #7: The plan of care established on 01/07/14 did not include the frequency of Dulcolax 5 mg two tablets PRN for bowel function. Interview with agency director on 01/22/14 at approximately 10 AM: Acknowledged and agreed with findings and could provide no additional documentation. *(Additional similar examples were attached for Record #2,4 and 12)*	G 159	The Agency Director (AD) and Director of Patient Services(DPS) met to review the organization policy and procedures related to the development of the plan of care, following the plan of care and the need for staff to alert the physician to any changes that suggest a need to alter the plan of care. No revisions were necessary, The Nursing Supervisors contacted the physicians to clarify orders for all patient cases cited. The DPS and Nursing Supervisors reviewed their current caseload to determine if additional patients may have the same issues. Medication profiles were updated in two additional cases. The AD and DPS have begun to meet with the visiting staff, employees and contractors. Two meetings with contract therapists and 2 meetings with nursing staff will occur by 2/24/14. The meetings have/will address all aspects of their responsibilities related to the following the plan of care including frequency and duration, ordered interventions, medications and the need to contact the physician to alter the plan when needed. The DPS or designees will review 100% of all applicable records related to the plan of care until 95% compliance attained then 10% or at least 5 applicable records will be reviewed quarterly to maintain compliance within 90%. Staff retraining and increased record reviews will occur as needed to restore compliance if the compliance falls below the compliance expectation. The AD and DPS will institute staff discipline if needed. The AD and DPS will present the record review findings to the Performance Improvement and Advisory Groups for review and action. Results of PI will be presented to the Governing Body for review and action. The Agency Director is ultimately responsible for the plan of correction.	3/1/14

G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview the agency failed to assure agency staff promptly alerts the physician to any changes that suggest a need to alter the plan of care in, but not limited to, five of twelve records (Records, #3, #6, #8, #10, and #13). The deficient practice has potential to affect all patients receiving services from this agency **Findings are:** Record #3: The physical therapy assistant documented on the visit note on 01/07/14 the patient had fallen in the hallway. The Physical therapy assistant failed to coordinate with the supervising physical therapist, the case manager skilled nurse or the physician to discuss the fall. The skilled nurse documented in the visit note on 01/14/14 that the patient complained of dizziness. The skilled nurse failed to report this new symptom to the physician. Interview with agency director on 01/22/14 at approximately 11:15 AM: Acknowledged and agreed with findings and could provide no additional documentation.. *(Additional similar examples were attached for Record #6,8,10 and 13)*	G 164	The Agency Director (AD) and Director of Patient Services(DPS) met to review the organization policy and procedures related to the plan of care and promptly alerting the physician to any changes that suggest a need to alter the plan of care. The Nursing Supervisors reviewed their current caseloads to determine if additional patients had unreported incidents. No additional patients were identified. The AD and DPS have begun to meet with the visiting staff, employees and contractors. Two meetings with contract therapists and 2 meetings with nursing staff will occur by 2/27/14. The meetings have/will address all aspects of their responsibilities related the need to promptly contact the physician to alter the plan when needed and to document the contact. The DPS or designees will review 100% of all applicable records related to the plan of care until 95% compliance attained then 10% or at least 5 applicable records will be reviewed quarterly to maintain compliance within 90%. Staff retraining and increased record reviews will occur as needed to restore compliance if the compliance falls below the compliance expectation. The AD and DPS will institute staff discipline if needed. The AD and DPS will present the record review findings to the Performance Improvement and Advisory Groups for review and action. Results of PI will be presented to the Governing Body for review and action. The Agency Director is ultimately responsible for the plan of correction.	3/1/14

Example 2 G156 ACCEPTANCE OF PATIENTS, POC, MED SUPER

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G 156	ACCEPTANCE OF PATIENTS, POC, MED SUPER This CONDITION is not met as evidenced by: Based on clinical record review, home visit observation, and staff interview it was determined that the agency. failed to meet the requirements for the Condition of Participation: Acceptance of Patients, Plan of Care, and Medical Supervision when the agency failed to: -- Assure staff followed the written plan of care as ordered by the physician (G158) -- Assure development of a complete and accurate plan of care for each patient receiving home health services (G159) -- Assure agency staff promptly alerted the physician to any changes that suggest a need to alter the plan of care (G164) The cumulative effect of these systemic practices resulted in the agency ' s inability to ensure that the patient ' s health care needs would be met by the home health agency.	G 156	DPS & Admin in-serviced all clinical and therapy staff on agency policy regarding Staffing & Scheduling, procedure to complete a missed visit note in the computer, ROC and reporting to physician. DPS created an auto generated reminder to all clinical & Therapy staff cell phone .to contact Scheduling Coordinator daily to report missed visits & complete missed visit notes in the computer call to Scheduler to reschedule visits if unable to complete before the end of the week. The Nursing Supervisors contacted the physicians to report the missed visits and performed ordered additional visits the week of 1/27/14 where ordered. The DPS and Nursing Supervisors reviewed their current caseload to determine if additional patients may have the same issues and action taken as ordered. Admin and DPS reviewed with Scheduling Coordinator importance of reviewing visit frequency when scheduling visits on calendar. DPS and Admin in-serviced all clinical and therapy staff on ensuring that visit frequency matches orders. DPS and Admin in-serviced all clinical and therapy staff on procedure to complete a missed visit note in the computer. PAC reviewed and approved policy on Staffing & Scheduling and sample of how to complete a missed visit note. GB approved policy. The DPS or designees will review 100% of all applicable records related to the plan of care, ROC and reporting to physcians until 95% compliance attained then 10% or at least 5 applicable records will be reviewed quarterly to maintain compliance within 90%. Staff retraining and increased record reviews will occur as needed to restore compliance if the compliance falls below the compliance.	2/27/14

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 and record review, the agency failed to reschedule missed visits and to notify the physician of missed home visits for four out of 11 sampled patients (Records #8 , 11, 15 and 17). This has the potential for adverse medical outcomes. **Findings:** The clinical record for Patient 8 was reviewed on 1/14/14 at1 1:15 AM. The Physician Orders dated 12/12/13 indicated that Patient 8 was to receive home health visits 2 times a week for 3 weeks. Review of Patient 8's clinical records indicated Patient 8 was seen only one time during the week of 12/30/13. No record could be located that the physician had been notified of the missed visit or that it had been rescheduled. During a concurrent record review of Patient 8's clinical record and interview with the Administrator on 1/3/14 at 10:15 AM, she stated, "The home• visit for 12/27/13 had been missed and was not rescheduled. Staff are to notify the Scheduling Coordinator to reschedule a home visit. The physician should have been called and notified of the missed visit. *(Additional similar examples were attached for Record #11, 15 and 17)*	G 158	DPS & Admin in-serviced all clinical and therapy staff on agency policy regarding Staffing & Scheduling. DPS and Admin in-serviced all clinical and therapy staff on procedure to complete a missed visit note in the computer DPS created an auto generated reminder to all clinical & Therapy staff cell phone .to contact Scheduling Coordinator daily to report missed visits & complete missed visit notes in the computer call to Scheduler to reschedule visits if unable to complete before the end of the week. The Nursing Supervisors contacted the physicians to report the missed visits and performed ordered additional visits the week of 1/27/14 where ordered. The DPS and Nursing Supervisors reviewed their current caseload to determine if additional patients may have the same issues. Missed visits were found in 2 additional cases and the physicians were contacted and additional visits were provided for the two patients. Admin and DPS reviewed with Scheduling Coordinator importance of reviewing visit frequency when scheduling visits on calendar. DPS & Admin in-serviced all clinical and therapy staff on agency policy regarding Staffing & Scheduling. DPS and Admin in-serviced all clinical and therapy staff on ensuring that visit frequency matches orders. DPS and Admin in-serviced all clinical and therapy staff on procedure to complete a missed visit note in the computer. PAC reviewed and approved policy on Staffing & Scheduling and sample of how to complete a missed visit note. GB approved policy. The DPS or designees will review 100% of all applicable records related to the plan of care until 95% compliance attained then 10% or at least 5 applicable records will be reviewed quarterly to maintain compliance within 90%. Staff retraining and increased record reviews will occur as needed to restore compliance if the compliance falls below the compliance expectation. The is Administrator is ultimately responsible for the plan of correction.	2/27/14

G159	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to address a potential change of condition when one patient (9) was hospitalized with chest pain and there was no documentation by agency staff as to the outcome of the hospitalization. This had the potential for staff to be unaware of the pertinent physical condition and diagnos.es of the patient. **Findings:** During a concurrent record review for Patient 9 and interview with the Director of Patient Services (DPS) on 1/6/14, at 3:05 PM, it was noted that, after one initial SN (skilled nurse) visit on 11/11/13, there was a "Transfer to Inpatient Facility" form dated 11/14/13. The form indicated Patient 9 had been transferred to an acute care hospital due to chest pain. Upon further review of the record it was noted there was no documentation regarding the outcome of the patient. The DPS reviewed the record and was unable to find any documentation that addressed Patient 9's chest pain. The DPS stated, "I don't know why there isn't more •information about his chest pain."	G159	The Nursing Supervisor and RN made a joint visit to clarify the status of the chest pain on ROC. The DPS and Nursing Supervisors reviewed their current caseload to determine if additional patients may have the same issues. No further examples could be found. DPS and Admin in-serviced all clinical and therapy staff on check list required to perform ROC after a hospital stay. DPS and Admin in-serviced all clinical and therapy staff on procedure to complete ROC (post hospital) status with computer screen as example. PAC reviewed arid approved policy, ROC checklist and sample of how to complete frequency and orders. GB approved policy. DPS in-serviced QM staff on monitoring ROC diagnosis, orders, frequency, guidelines, to . ensure they match. Scheduling Coordinator to monitor master schedule for visit compliance to frequency as compared to ROC orders Scheduling Coordinator to notify DPS if non compliance occurs daily DPS to notify Admin if non-compliance occurs. The DPS or designees will review 100% of all applicable records related to the plan of care until 95% compliance attained then 10% or at least 5 applicable records will be reviewed quarterly to maintain compliance within 90%. Staff retraining and increased record reviews will occur as needed to restore compliance if the compliance falls below the compliance expectation. The DPS and Admin will institute staff discipline if needed. The DPS and Admin will present the record review findings to the Performance Improvement and Advisory Groups for review and action. Results of PI will be presented to the Governing Body for review and action. The is Administrator is ultimately responsible for the plan of correction.	3/1/14

G 164	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the agency failed to ensure the physician was notified promptly of a change in the patient's condition for one of 20 sampled patients (20). This had the potential for the patient's condition to be treated in an untimely manner by the physician. **Findings:** During .Patient 20's home visit observation, on 1/10/14, at 2:30 PM, Licensed Practical Nurse (LPN) proceeded to take the blood pressure (BP). The BP taken while the patient was sitting was 136/70 and the BP while standing was 108/58 (which was a drop in the systolic BP •of 28mm/ Hg [millimeters of Mercury] and a drop of the diastolic BP of 12 mm/Hg). LPN asked the patient what his latest blood sugar (BS) checks were and he replied, the BS at 12:30 PM today, was 387 milligrams per deciliter (mg/di) (normal range according to the American Diabetes Association for an individual with Diabetes is between 70-130 mg/di). At 2:44 PM, LVN asked the patient to check his blood sugar. The results were 417 mg/di. LVN then proceeded to contact the primary care physician (PCP), but there was no response and she stated she would attempt to contact the PCP later. During a review of the clinical record for Patient 20, the plan of care (POC) for the 12/26/13 - 2/23/14 certification period was reviewed. The list of Patient 2's diagnoses included type I Diabetes Mellitus and orthostatic hypotension (fall in the blood pressure [systolic drop of greater than 20 mm/Hg and diastolic drop of 10 mm/Hg] which may cause weakness, headache, lightheadedness, dizziness, falling, etc.). The skilled nursing visit (SNV) note for the 1/10/14 HV was reviewed. The note read, "SN again attempted to call (PCP) office regards insulin, but still no answer. SN called pt and spoke to wife, she states pt (patient 20) blood glucose has gone down to 360..." A late entry dated 1/11/14, at 8:10 AM and 6 PM, indicated LPN attempted to contact Patient 20's (PCP) but was unable to. No other documentation was noted the patient's PCP was contacted on 1/12/14 in regards to the elevated blood sugar or the abnormal blood pressure drop.	G 164	The Nursing Supervisors reviewed their current caseloads to determine if additional patients had unreported incidents. No additional patients were identified. SN counseled on notifying M.D promptly of change in patient's condition. • DPS & Admin in-serviced.all clinical an therapy staff on policy Monitoring Patients Response/Reporting to Physician. DPS and Admin in-serviced all clinical and therapy staff on policy Patient Change in Condition. DPS and WG/IC Manager in-serviced all clinical and therapy staff on DM, FSBS, sliding scale, DM medications, DM S/S, Nutrition, DM • Wounds and healing and administered Competency testing to Nursing Staff. DPS and WC/IC Manager in-serviced all clinical and therapy staff on Apical pulse, Irregularities in BP, VS, use of Pulse OX, FSBS parameters and sample sliding scales. DPS and WC/IC Manager in-serviced all clinical and therapy staff on Policy and Fax/Order form identifying Patient Key Health Parameters requiring MD response. PAC reviewed and approved policies, Fax/Order form. GB approved policies, Fax/Order form. The DPS or designees will review 100% of all applicable records related to the reporting to physician until 95% compliance attained then 10% or at least 5 applicable records will be reviewed quarterly to maintain compliance within 90%. Staff retraining and increased record reviews will occur as needed to restore compliance if the compliance falls below the compliance expectation. The DPS and Admin will institute staff discipline if needed. The DPS and Admin will present the record review findings to the Performance Improvement and Advisory Groups for review and action. Results of PI will be presented to the Governing Body for review and action. The is Administrator is ultimately responsible for the plan of correction.	3/1/14