Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	NVS540HHA		05/15/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE STAR HOME HEALTH CARE INC	6420 SPRING MOUNTAIN RD. STE. #18 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) COMPLETE DATE
H 00	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of an annual State licensure survey conducted on May 15, 2009. The state license survey was conducted in accordance with Chapter 449, Home Health Agencies, adopted by the State Board of Health November 28, 1973, last amended November 17, 2005. 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 census was 245. Three patient files were reviewed. The following regulatory deficiencies were noted:	H 00		
H152	449.782 Personnel Policies A home health agency shall establish written policies concerning the qualification, responsibilities and conditions of employment for each type of personnel, including licensure if required by law. The written policies must be reviewed as needed and made available to the members of the staff and the advisory groups. The personnel policies must provide for: 6. The maintenance of employee records which confirm that personnel policies are followed; This Regulation is not met as evidenced by: NRS 449.173 (3) Initial and periodic investigations of criminal history of employee or independent contractor of	H152		

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deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 6/19/09

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NAME OF PROVIDER OR SUPPLIER: FIVE STAR HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE: 6420 SPRING MOUNTAIN RD. STE. #18 LAS VEGAS, NV 89146		

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H152	Continued From page 1 certain agency or facility. 3. The administrator of, or the person licensed to operate, an agency to provide personal care services in the home, an agency to provide nursing in the home, a facility for intermediate care, a facility for skilled nursing or a residential facility for groups shall ensure that the criminal history of each employee or independent contractor who works at the agency or facility is investigated at least once every 5 years. The administrator or person shall: (a) If the agency or facility have the fingerprints from the employee or independent contractor; (b) Obtain written authorization from the employee or independent contractor to forward the fingerprints on file or obtained pursuant to paragraph (a) to the Central Repository for Nevada Records of Criminal History for submission to the Federal Bureau of Investigation for its report; and (c) Submit the fingerprints to the Central Repository for Nevada Records of Criminal History. Based on record review and staff interview, the agency failed to maintain updated background checks for 4 of 14 sampled employees. (#2, #3, 10, and #12). Findings include: Employee #2: Fingerprints in file were dated 10/3/03. Employee #3: Fingerprints in file were dated 10/28/97; there was no State and FBI clearance in the file. Employee #10: Fingerprints in the file were dated 2/25/02. Employee #12: Fingerprints in the file were dated 6/20/01. On 5/15/09 at 3:00 PM, an interview with the Director of Patient Care Services revealed, the	H152	A. Personnel # 2, 3, 10 and 12 did new set of fingerprint and were sent to DPS Records and Technology Division. Exhibits A1,2,3,4 B. 100% audit of all personnel file to update all fingerprints by end of June 2009. C. 1.Memo to Personnel Department from Administrator re FP should be done once every 5 years. Exhibit A5 2. Personnel Checklist Form to reflect next due date of fingerprinting. Exhibit A6 D. Monthly Audit of all personnel file to check FP date until the end of this year. Report to be filed in CQI. Exhibit A7 RECEIVED	6/30/09

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H152	Continued From page 2 agency's Human Resources audited the personnel files recently and were in the process of updating the files. Severity: 2 Scope: 2	H152		
H153	449.782 Personnel Policies A home health agency shall establish written policies concerning the qualification, responsibilities and conditions of employment for each type of personnel, including licensure if required by law. The written policies must be reviewed as needed and made available to the members of the staff and the advisory groups. The personnel policies must provide for: 7. The annual testing of all employees who have contact with patients for tuberculosis pursuant to NAC 441A.375; and This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to comply with NAC 441.A for 1 of 14 employees (#12). Findings include: NAC 441A.375 3. Before initial employment, a person employed in a medical facility, a facility for the dependent or a home for individual residential care shall have a: (b) Tuberculosis screening test within the preceding 12 months, including persons with a history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the first step	H153		

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H153	Continued From page 3 of a 2-step Mantoux tuberculin skin test within the preceding 12 months, then the second step of the 2-step Mantoux tuberculin skin test or other single-step tuberculosis screening test must be administered. A single annual tuberculosis screening test must be administered thereafter, unless the medical director of the facility or his designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of testing and documents that determination. The risk of exposure and corresponding frequency of examination must be determined by following the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 4. An employee with a documented history of a positive tuberculosis screening test is exempt from screening with skin tests or chest radiographs unless he develops symptoms suggestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to a chest radiograph and medical evaluation for active tuberculosis. 6. Counseling and preventive treatment must be offered to a person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. A medical facility shall maintain surveillance of employees for the development of pulmonary symptoms. A person with a history of tuberculosis or a positive tuberculosis screening test shall report promptly to the infection control specialist, if any, or to the director or other person in charge of the medical facility if the medical facility has not designated an infection control	H153	RECEIVED JUN 19 2009 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA	

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H153	Continued From page 4 specialist, when any pulmonary symptoms develop. If symptoms of tuberculosis are present, the employee shall be evaluated for tuberculosis. Review of Employee #12's file revealed the tuberculosis screening test was administered on 2/15/08; The result was read on 2/19/08. The time between administering and reading of the test was greater than 72 hours. Severity: 2 Scope: 1	H153	A. Personnel # 12 did his PE for this year 2009 with TB test read within 48-72 hrs. Exhibit B1 B. 100% audit of all personnel file to update all TB test results were read within 48-72 hrs by end of June 2009. C. 1.Memo to Personnel Department from Administrator re TB results should be read within 48-72 hrs after administering the test. Exhibit B2 2. Personnel Checklist Form to reflect TB test results read within 48-72 hrs. Exhibit B3 D. Monthly Audit of all personnel file who received TB test to check timely reading of results. Report to be filed in CQI. Exhibit B4	6/30/09
H184	449.797 Contents of Clinical Records Clinical records must contain: 1. The name, address and telephone number of hte person who will be notified in an emergency involving the patient. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to provide emergency contact information for 2 of 3 patients (#2 and #3). Findings include: The agency admitted Patient #2 on 3/11/09 with diagnoses of knee wound, knee pain, fall, difficulty in walking, and diabetes. The agency admitted Patient #3 on 4/28/09 with diagnoses of chronic obstructive pulmonary disease exacerbation, right hip fracture, right hip pain, bilateral lower extremity weakness, and hypertension. On 5/15/09 in the afternoon, the Director of Patient Care Services indicated emergency contact information should be on the referral sheets or somewhere in the chart.	H184		

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H184	Continued From page 5 The files for Patient #2 and #3 lacked documented evidence of emergency contact information. Severity: 1 Scope: 3	H184	A. Pt #3 Referral Intake Sheet was completed. Pt #2 was already discharged from services and can't contact said pt even after numerous attempts. Exhibits C1 and 2 B. 100% audit of all patients admitted from the 1st to the 15th of this month to update emergency contact. C. 1.Memo to all Clinicians, QA coordinators and Liaisons to always obtain the pt's emergency contact's name, address, telephone number and relationship to the patient. Exhibit C3 2. In-service meeting done on June 10, 2009 re patient emergency contact. Exhibit C4 3.Admission Assessment Checklist Form to be used to all pts admitted into the service. Exhibit C5 D. Monthly 10% Audit of clinical records of all admitted patients until the end of Dec. 2009. Report be filed in CQI. Exhibit C6	6/10/09
H188	449.797 Contents of Clinical Records Clinical records must contain: 5. A copy of: (a) The patient's durable power of attorney for heath care, if the patient has executed such a power of attorney pursuant to NRS 449.800 to 449.860, inclusive; and (b) A declaration governing the withholding or withdrawal of life-sustaining treatment, if the patient has executed such a declaration pursuant to NRS 449.600. This Regulation is not met as evidenced by: Based on record review and staff interview, the agency failed to have a copy of an advance directive for 1 of 3 patients (Patient #2). Findings include: The agency admitted Patient #2 on 3/11/09 with diagnoses of knee wound, knee pain, fall, difficulty in walking, and diabetes. Patient #2's file contained an advance directive acknowledgement dated 3/11/09. The directive indicated Patient #2 provided a copy of the advance directive to the agency. Patient #2's file lacked a copy of an advance directive.	H188	RECEIVED JUN 19 2009 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA	

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H188	Continued From page 6 On 5/15/09 in the afternoon, the Director of Patient Care Services indicated Patient #2 probably did not provide a copy of the advance directive. Severity: 2 Scope: 2	H188	A. Intake RN stated that she inadvertently checked 'yes' (pt provided a copy of DPA). See attached Incident Report as Exhibit D1 B. 100% audit of all patients admitted from the 1st to the 15th of this month to update Advance Directives. C. 1.Memo to all Clinicians and QA coordinators regarding Advance Directive. Exhibit D2 2. In-service meeting done on June 10, 2009 re patient's advance directive. Exhibit D3 3.Admission Assessment Checklist Form reflecting Adv. Directive to be used to all pts admitted into the service. Exhibit D4 D. Monthly 10% Audit of clinical records of all admitted patients until the end of Dec. 2009. Report be filed in CQI. Exhibit D5	
H191	449.797 Contents of Clinical Records 8. A written evaluation for services made at the time the patient is admitted for care. Regular written reevaluations for services and assessments of patients made on a continuing basis. This Regulation is not met as evidenced by: Based on staff interview and record review, the agency failed to complete a nursing assessment at admission for 1 of 3 patients (#1). Findings include: The agency admitted Patient #1 on 3/10/09 with diagnoses of general muscle weakness and seizures. On 3/10/09 at 5:35 PM, a physician ordered a skilled nurse to do an initial evaluation. On 5/15/09 in the afternoon, the Director of Professional Care Services indicated Patient #1 was a veteran and did not require an OASIS comprehensive assessment. Patient #1's file contained a blank OASIS assessment. On 5/29/09 in the morning, the Director of Professional Care Services faxed Patient #1's initial evaluation. The assessment indicated	H191	RECEIVED JUN 19 2009 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA	6/10/09

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H191	Continued From page 7 Patient #1's functional limitation was endurance due to dyspnea. The agency's skilled nurse left the following assessment areas blank: vital signs, ears/eyes/nose/throat, skin, respiratory, cardiovascular, endocrine, gastrointestinal, genitourinary, and nutrition. Severity: 2 Scope: 2	H191	A. NO skilled nursing service was provided for this patient – only Physical Therapist (PT). See attached pt's 485 as Exhibit E1 B. It's the agency's practice that Physical Therapist doesn't need to fill up the vital signs, eyes/ears/nose/throat, skin, respiratory, cardiovascular, endocrine, gastrointestinal, genitourinary and nutrition part of the intake assessment sheet.	
H193	449.797 Contents of Clinical Records 10. A record of the termination of services, including the date and reason for termination and the time when the physician was notified of the termination. This Regulation is not met as evidenced by: Based on record review, observation and staff interview, the agency failed to produce a discharge summary for 2 of 3 patients (#1 and #2). Findings include: The agency admitted Patient #1 on 3/10/09 with diagnoses of general muscle weakness and seizures. On 5/15/09 in the afternoon, record review of Patient #1's records revealed a lack of a discharge summary from the agency. On 5/15/09 in the afternoon, an interview with the Director of Patient Care Services (DOPS) revealed, Patient #1 was a "VA patient" and did not require a discharge summary. The agency admitted Patient #2 on 3/11/09 with diagnoses of knee wound, knee pain, fall, difficulty in walking, and diabetes.	H193	A. Pts # 1 and 2 DC Summary were completed. Exhibit F1,2,3 B. 100% audit of all patients discharged from the 1st to the 15th of this month to update DC summary by the end of June 2009. C. 1.Memo to all Clinicians regarding DC summary. Exhibit F4 2. In-service meeting done on June 10, 2009 re DC summary. Exhibit F5 D. Monthly 10% Audit of clinical records of all discharged patients until the end of Dec. 2009. Report be filed in CQI. Exhibit F6 RECEIVED JUN 19 2009 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA	6/30/09 6/10/09

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H193	Continued From page 8 On 5/15/09 in the afternoon, record review of Patient #2's records lacked recertification orders and/or a discharge summary. Patient #2's prior certification period ended on 5/9/09. On 5/15/09 in the afternoon, an interview with the DOPS revealed Employee #15 was called in to complete Patient #2's discharge summary. On 5/15/09 at 5:15 PM, Employee #15 was observed completing Patient #2's discharge summary. Severity: 1 Scope: 3	H193		
H195	449.800 Medical Orders 2. Initial medical orders, renewals and changes of orders for skilled nursing an d other therapeutic services submitted by telephone must be recorded before they are carried out All medical orders must bear the signature of the physician who initiated the order within 20 working days after receipt of the oral order. This Regulation is not met as evidenced by: Based on record review, the agency failed to obtain signatures on medical orders within 20 working days for 2 of 3 patients (#1 and #2). Findings include: The agency admitted Patient #1 on 3/10/09 with diagnoses of general muscle weakness and seizures. Patient #1's file contained admission orders and a	H195	RECEIVED JUN 19 2009 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA	

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H195	Continued From page 9 plan of care dated 3/10/09; the physician signed both on 4/10/09. The agency admitted Patient #2 on 3/11/09 with diagnoses of knee wound, knee pain, fall, difficulty in walking, and diabetes. Patient #2's file contained admission orders and a plan of care dated 3/11/09; the physician signed both on 4/16/09. Patient #2's file contained an order for a social worker evaluation dated 3/17/09; the physician signed the order on 4/16/09. Severity: 1 Scope: 3	H195	A. Pts # 1 and 2 MD orders had already been signed but not in a timely manner, as noted by the surveyors. B. 10% audit of clinical records of all patients admitted from the 1st to the 15th of this month for compliance of MD orders signature before the end of June 2009. C. 1.Memo to all clinicians regarding timely signature of medical orders. Exhibit G1. 2. In-service meeting done on June 10, 2009 re timely signature of medical orders. Exhibit G2 3. Cover sheets to be used by medical records manager in sending out/follow up of MD orders for signature and tracking sheet. Exhibit G3,4,5 D. Monthly 10% Audit of all clinical records of all patients for the month until the end of Dec. 2009. Report be filed in CQI. Exhibit G6	6/30/09
H199	449.800 Medical Orders 7. All orders must be renewed in writing by the physician at least every 62 days. This Regulation is not met as evidenced by: Based on record review, staff interview and observation, the agency failed to recertify 1 of 3 patients prior to the end of a certification period (#2). Findings include: The agency admitted Patient #2 on 3/11/09 with diagnoses of knee wound, knee pain, fall, difficulty in walking, and diabetes. Patient #2's file revealed the certification period ended on 5/9/09. Patient #2's file lacked documented evidence of a discharge on 5/9/09 or before.	H199	RECEIVED JUN 19 2009 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA	

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H199	Continued From page 10 Patient #2's file contained a telephone communication dated 5/11/09. The above telephone communication note indicated the following: "per [....] [Employee #15], she will discharge the patient due to pt [patient] refusing further visits. I informed [...] P.T. [physical therapy] about the SN [skilled nurse] discharge." Patient #2's file lacked recertification orders beginning 5/10/09. On 5/15/09 in the afternoon, the Director of Patient Care Services indicated she called in Employee #15 to complete Patient #2's OASIS discharge summary. On 5/15/09 at 5:15 PM, observation revealed Employee #15 completing Patient #2's OASIS discharge summary. Severity: 2 Scope: 2	H199	A. Pts # 2 was discharged at the end of cert. Period. See attached DC order and DC summary. Exhibits H1and 2 B. 100% audit of clinical records of all patients discharged/recertified from the 1st to the 15th of this month for compliance of MD orders are in place by the end of June 2009. C. 1.Memo to all clinicians regarding discharging/recertifying patients. Exhibit H3 2. In-service meeting June 10, 2009 Exhibit H4 D. 10% Audit of all clinical records of discharged/recertified patients until the end of this Dec. 2009. Exhibit H5	6/30/09
H200	449.800 Medical Orders 8. New orders are required when there is a change in orders, a change of physician or following hospitalization. This Regulation is not met as evidenced by: Based on record review, the agency failed to obtain new orders for a change to the plan of care for 1 of 3 patients (#2). Findings include: The agency admitted Patient #2 on 3/11/09 with diagnoses of knee wound, knee pain, fall, difficulty in walking, and diabetes.	H200		

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NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6420 SPRING MOUNTAIN RD. STE. #18 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) COMPLETE DATE
H200	Continued From page 11 Patient #2's plan of care indicated a weekly skilled nursing visit. Patient #2's last documented skilled nursing visit was 4/27/09. Patient #2's file lacked documented evidence of a skilled nursing visit between 4/27/09 and 5/9/09. Patient #2's file lacked an order discontinuing skilled nursing visits between 4/27/09 and 5/9/09. Severity: 2 Scope: 2	H200	A. Pts # 2 frequency of SN visit is 1x/wk (see 485 Exhibit I 1 On the week of 4/26 to 5/2/09 an actual visit was done on 4/27 as noted by the surveyors. On the week of 5/3 to 5/9/09 patient was discharged due to refusal of further visits. See attached telephone communication and DC order. Exhibit H1 B. 100% audit of all clinical records of all patients discharged/recertified from June 1st to the 15th 2009 to check compliance of MD orders are in place by the end of June 2009. C. 1.Memo to all clinicians regarding discharging/recertifying patients. Exhibit H3 2. In-service meeting June 10, 2009 Exhibit H4 D. 10% Audit of all clinical records of discharged/recertified patients until the end of this Dec. 2009. Exhibit H5	6/30/09

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

RECEIVED
JUN 19 2009
BUREAU OF LICENSURE AND CERTIFICATION
LAS VEGAS, NEVADA