IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
KARL B. KURTZ – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

August 29, 2006

CERTIFIED MAIL # 7003 0500 0003 1967 0186

Stephanie Godinez, R.N., Administrator
Crest Home Health Inc.
101 Ironwood Drive, Suite 230
Coeur d' Alene, ID 83814

FILE COPY

Dear Ms. Godinez:

On July 20, 2006, a Medicare Survey was concluded at Crest Home Health Inc.

To date, this office has not received your Plan of Correction for that survey. Your Plan of Correction was to be submitted by August 23, 2006. Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing licensure deficiencies.

You have until September 11, 2006 to submit a Plan of Correction to this office. If it is not submitted in a timely manner, the Department may pursue an enforcement procedure.

If you have any questions regarding this matter, please contact this office at (208) 334-6626.

Sincerely,

SYLVIA CRESWELL
Supervisor
Non-Long Term Care Program

SC/slc

Enclosure

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

August 10, 2006

CERTIFIED MAIL #: 7003 0500 0003 1966 8824

Stephanie Godinez, R.N., Administrator
Crest Home Health Inc.
101 Ironwood Drive, Suite 230
Coeur d'Alene, ID 83814

FILE COPY

Dear Ms. Godinez:

This is to advise you of the findings of the Medicare survey for Crest Home Health Inc. (Provider # 137070), which was concluded on July 20, 2006.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567 listing Medicare deficiencies. A similar form listing state licensure deficiencies is also included. In the spaces provided on the right side of the page, answer **each** deficiency accordingly:

- Describe how the problem will be corrected so that it does not continue to recur (do not address the examples and/or explain why the deficiency occurred);
- Identify who will monitor the deficient system to insure continued compliance;
- Indicate when and how often monitoring will occur; and
- Provide the date by which each deficiency will be, or has been, corrected.

After each deficiency has been answered, **sign and date** the Plan of Correction in the spaces provided at the bottom of the first page of each report. Return the originals to this office by **August 23, 2006**.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626.

Sincerely,

GARY GUILES, R.N.
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

GG/SC/sm

Enclosures

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

PRINTED: 08/10/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	137070		07/20/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HOME HEALTH INC	101 IRONWOOD DR STE 230 COEUR D'ALENE, ID 83814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey for your home health agency. The surveyors conducting the survey were: Deb Dore', RN, HFS, Team Coordinator Gary Guiles, RN, HFS	G 000	RECEIVED AUG 29 2006 FACILITY STANDARDS	
G 160	484.18(a) PLAN OF CARE If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure physicians were consulted to approve additions or modification to original plans of care that could not be completed until after an evaluation visit for 3 of 13 sampled patients whose records were reviewed (#s 4, 9, & 10). The findings include: 1. Patient #9 was admitted for home health services on 6/27/06. The patient's plan of care for the certification period 6/27/06 to 8/25/06 was not dated. The plan of care documented the following orders: Physical Therapy, 2 visits a week for 1 week and 3 visits a week for 3 weeks. Occupational therapy, 1 visit for evaluation. The physical therapist evaluated the patient on	G 160	**G 160: PLAN OF CARE** *Ongoing* Agency Administrator will educate all professional employees by 08/23/2006 on required documentation as it relates to physician notification after initial evaluation is completed, and the documentation required to show physician approval for additions/modifications to original plan of care. A place for notification of Physician shall be included on all admission evaluation forms. Agency Administrator will audit 100% of new admission charts to ensure it contains interim plan of care orders through 11-30-2006 and then 10% of admissions for the following 3 months. Clinical Program Department will also audit for the same appropriate paperwork and documentation during quarterly audits on an ongoing basis. Policy 200.34 (Attachment A)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jodiner RN
TITLE: Administrator
(X6) DATE: 08.23.06

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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G 160	Continued From page 1 6/28 and developed a plan of care. The occupational therapist evaluated the patient on 6/29 and developed a plan of care. The two therapists continued to see the patient after the evaluation visit. There was no documentation of communication between nursing/therapy and the physician to approve the therapy plans of care, even though the therapist implemented the new plans. In addition, the 485 plan of care had no physician signature at the time of review, 7/18/06. An interview was conducted with the Director/Administrator on 7/19/06 at 9:30 AM. She confirmed there was no documentation the nurse or therapist had communicated with the physician to approve the therapy plans of care. 2. Patient #4 was admitted for home health services on 7/6/06. The patient's plan of care for the certification period 7/6/06 to 9/3/06 was not dated. The plan of care documented the following orders: Physical Therapy, 3 visits a week for 2 weeks. Occupational Therapy, 1 visit a week for 1 week, 3 visits a week for 3 weeks. The physical therapist evaluated the patient on 7/6 and developed a plan of care. The occupational therapist evaluated the patient on 7/6 and developed a plan of care. The two therapists continued to see the patient after the evaluation visit. There was no documentation of communication between nursing/therapy and the physician to approve the therapy plans of care, even though the therapist implemented the new plans. The 485 plan of care had not been signed by the physician at the time of review, 7/18/06. An interview was conducted with the	G 160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HOME HEALTH INC	101 IRONWOOD DR STE 230 COEUR D'ALENE, ID 83814

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G 160	Continued From page 2 Director/Administrator on 7/19/06 at 9:30 AM. She confirmed there was no documentation the nurse and the therapists had communicated with the physician for the additions to the plan of care. 3. Patient #10 was admitted for home health services on 12/12/05. The patient's plan of care for the certification period 12/12/05 to 2/9/06 documented the following orders: Physical Therapy, 2 visits a week for 1 week, 3 visits a week for 3 weeks. The physical therapist evaluated the patient on 7/6 and developed a plan of care. The therapist continued to see the patient after the evaluation visit. There was no documentation of communication between nursing/therapy and the physician to approve the therapy plan of care, even though the therapist implemented the new plan. An interview was conducted with the Director/Administrator on 7/19/06 at 9:30 AM. She confirmed there was no documentation that staff had communicated with the physician for the additions to the plan of care.	G 160	**G 166: Conformance with Physician Orders** Agency Administrator will educate all professional employees by 08/23/2006 on required physician notification regarding changes in the patient's condition that may have occurred between certification period and obtain approval for re-certification. All verbal orders will be put in writing and signed/dated by attending physician. A place for notification of Physician shall be included on all re-certification evaluation forms. Agency Administrator to audit 100% of all re-certification patient charts for interim faxed or telephone order with 485 to follow for physician notification for upcoming re-certification period through 11-30-2006 and then 10% of re-certification charts for the following 3 months. Clinical Program Department will also audit for the appropriate paperwork and documentation during quarterly audits on an ongoing basis. Policy 200.38 (Attachment B)	*Ongoing*
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by:	G 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	137070		07/20/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HOME HEALTH INC	101 IRONWOOD DR STE 230 COEUR D'ALENE, ID 83814

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G 166	Continued From page 3 Based on record review and staff interview it was determined the agency failed to ensure orders were obtained at the time of recertification of care for 3 of 4 sampled patients who required recertification (#s 2, 5, & 7). The findings include: 1. Patient #2 was admitted for home health services on 12/12/05. The patient's plan of care for the certification period 6/10/06 to 8/8/06 documented the following: Skilled Nursing, 3 times a week for 8 weeks, 1 time a week for 1 week. "SKILLED NURSE TO OBSERVE AND ASSESS VITAL SIGNS, PAIN, SKIN, AND GI/NUTRITIONAL SYSTEM AT EACH VISIT. SKILLED NURSE TO PERFORM WOUND CARE TO COCCYX AT EACH VISIT AS FOLLOWS: CLEANSE WITH NORMAL SALINE, IRRIGATE WITH NORMAL SALINE, PAT DRY WITH 4X4 GAUZE, SKIN-PREP PERI-WOUND, APPLY MULTIDEX TO WOUND BED AND COVER WITH ABSORBANT COMER DRESSING. SKILLED NURSE TO DO PATIENT/CAREGIVER TEACHING REGARDING WOUND CARE AND TREATMENT REGIMEN AS NEEDED. SKILLED NURSE TO PERFORM RECTAL DIGITAL CHECK PRN [as needed] FOLLOWING PATIENT'S BOWEL PREP FOR RECTAL CLEARANCE AT PATIENT REQUEST." There was no documentation the physician had approved the recertification orders. An interview was conducted with the Director/Administrator on 7/19/06 at 9:30 AM. She confirmed there was no documentation of physician approval for the recertification orders.	G 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	137070		07/20/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HOME HEALTH INC	101 IRONWOOD DR STE 230 COEUR D'ALENE, ID 83814

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G 166	Continued From page 4 2. Patient #5 was admitted for home health services on 3/13/06. The patient's plan of care for the certification period 5/12/06 to 7/10/06 documented the following: Skilled Nursing, 1 time a month for 2 months. "SKILLED NURSE TO OBSERVE AND ASSESS SKIN, HOME SAFETY, VITAL SIGNS AND ENDOCRINE SYSTEM AT EACH VISIT. SKILLED NURSE TO PRE-FILL MONTHLY INSULIN SUPPLY 22U LANTUS INSULIN PER SYRINGE FOR DAILY ADMINISTRATION Q [every] MONTH. SKILLED NURSE TO DO PATIENT TEACHING/REMINDERS PRN REGARDING DISEASE PROCESS, S/S [signs/symptoms] OF COMPLICATIONS, MEDICATION REGIMEN. DIABETIC CARE AND HOME SAFETY AT EACH VISIT." There was no documentation the physician approved these recertification orders. An interview was conducted with the Director/Administrator on 7/19/06 at 9:300 AM. She confirmed there was no documentation of physician approval for the recertification orders. 3. Patient #7 was admitted for home health services on 10/15/99. The patient's plan of care for the certification period 7/4/06 to 9/1/06 documented the following: Skilled Nursing, 1 visit a month for 2 months, 2 as needed visits. "SKILLED NURSE TO OBSERVE AND ASSESS INTEGUMENTARY SYSTEM AND GENITOURINARY SYSTEM AT EACH VISIT. SKILLED NURSE TO OBTAIN VITAL SIGNS AT EACH VISIT. SKILLED NURSE TO CHANGE SUPRAPUBIC CATHETER EVERY MONTH	G 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HOME HEALTH INC	101 IRONWOOD DR STE 230 COEUR D'ALENE, ID 83814

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G 166	Continued From page 5 USING 20FR CATHETER, 5CC BALLOON TO DOWN DRAIN/LEG BAG. 2 PRN VISITS FOR CATHETER PROBLEMS." Home Health Aide, 2 visits a week for 9 weeks. "HOME HEALTH AIDE TO ASSIST WITH BATHING, ADL'S [activities of daily living], PERSONAL CARE, CATHETER CARE, SKIN CARE AND LIGHT HOUSEKEEPING AT EACH VISIT." There was no documentation the physician had approved the recertification orders. An interview was conducted with the Director/Administrator on 7/19/06 at 9:30 AM. She confirmed there was no documentation of physician approval for the recertification orders.	G 166	**G 236: Clinical Records** *Ongoing* Agency Administrator will educate all professional staff by 08/23/2006 that clinical and progress notes must be written or dictated on the day of service and will be rendered and incorporated into the clinical record within seven (7) days of the visit. A place for notification of Physician shall be included on all admission and re-certification evaluation forms.	
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 and staff interview, it was determined the agency failed to ensure patient clinical records for 4 of 13 sampled patients (#s 1, 2, 5, & 7) included pertinent current findings. The findings include:	G 236	Agency Administrator and or designee will audit 100% of charts through 11-30-2006, then 10% of charts thereafter for the following 3 months basis to ensure timely clinical record maintenance of pertinent past and current records in accordance with accepted professional standards. Clinical Program Department will also audit for the appropriate paperwork and documentation during quarterly audits on an ongoing basis. Policy 700.49 (Attachment C)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	137070		07/20/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HOME HEALTH INC	101 IRONWOOD DR STE 230 COEUR D'ALENE, ID 83814

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G 236	Continued From page 6 1. Patient #1 was admitted for home health services on 6/15/06. The patient's clinical record was reviewed on 7/18/06. The record did not contain the plan of care for the certification period 6/15/06 to 8/13/06, which was to be completed by 6/19/06. The record also lacked physical therapy notes from visits that were made on 6/16/06 and 6/26/06. An interview with the Director/Administrator was conducted on 7/18/06 at 2:00 PM. She stated the patient had refused occupational therapy but this was not documented. She confirmed the record was lacking the plan of care and physical therapy notes. She later stated that the plan of care had not been filed and the physical therapy notes had not been turned in. The missing documentation was later retrieved and placed in the record. 2. Patient #2 was admitted for home health services on 12/12/05. The patient's clinical record was reviewed on 7/18/06. The record did not contain nursing notes from visits that were completed on 6/12/06 and 6/14/06. An interview with the Director/Administrator was conducted on 7/19/06 at 9:30 AM. She confirmed the record was lacking the nursing notes. She later stated the nursing notes had not been filed. The missing documentation was later retrieved and placed in the record. 3. Patient #5 was admitted for home health services on 3/13/06. The patient's clinical record was reviewed on 7/18/06. The record failed to include a recertification assessment that should have been completed by 5/11/06 (the date the initial plan of care expired) and the plan of care for the certification period 7/11/06, which should	G 236		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	137070		07/20/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST HOME HEALTH INC	101 IRONWOOD DR STE 230 COEUR D'ALENE, ID 83814

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G 236	Continued From page 7 have been completed by 7/10/06. An interview with the Director/Administrator was conducted on 7/19/06 at 9:30 AM. She confirmed the record was lacking the assessment and plan of care. She later stated the assessment and plan of care had not been filed. 4. Patient #7 was admitted for home health services on 10/15/99. The patient's plan of care for the certification period 7/4/06 to 9/1/06 included orders for a home health aide. The patient's clinical record was reviewed on 7/18/06. The record did not include an aide plan of care. An interview with the Director/Administrator was conducted on 7/19/06 at 9:30 AM. She confirmed there was no home health aide plan of care in the record. She later stated the plan of care had been misfiled.	G 236		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137070	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 07/20/2006
NAME OF PROVIDER OR SUPPLIER CREST HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 IRONWOOD DR STE 230 COEUR D'ALENE, ID 83814		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
N 000	INITIAL COMMENTS The following deficiencies were cited during the State licensure survey for your home health agency. The surveyors conducting the survey were: Deb Dore', RN, HFS Team Coordinator Gary Guiles, RN, HFS	N 000	RECEIVED AUG 29 2006 FACILITY STANDARDS	
N 170	03.07030.04.PLAN OF CARE N170 04. Initial Plan of Care. The initial plan of care and subsequent changes to the plan of care are approved by a doctor of medicine, osteopathy, or podiatric medicine. This Rule is not met as evidenced by: Refer to Federal deficiency G160, as it relates to the failure of the agency to ensure the physician was consulted to approve additions and/or modifications to the original plan of care.	N 170		
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated	N 173		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Trudiner RN TITLE Administrator (X6) DATE 08-23-06

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137070	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/20/2006
NAME OF PROVIDER OR SUPPLIER CREST HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 IRONWOOD DR STE 230 COEUR D'ALENE, ID 83814		

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N 173	Continued From page 1 medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to Federal deficiency G166, as it relates to the failure of the agency to ensure physician's orders for recertification of care were obtained.	N 173		
N 180	03.07031.CLINICAL REC. N180 02. Contents. Clinical records must include: f. Signed and dated clinical and progress notes; This Rule is not met as evidenced by:	N 180		
N 186	03.07031.03.CLINICAL REC. N186 03. Clinical and Progress Notes, and Summaries of Care. Clinical and progress notes must be written or dictated on the day service is rendered and incorporated into the clinical record within seven (7) days. Summaries of care reports must be submitted to the attending physician at least every sixty (60) days. This Rule is not met as evidenced by: Refer to Federal deficiency G236, as it relates to the failure of the agency to ensure nursing and therapy notes were in the clinical record in a timely manner.	N 186		
N 188	03.07031.05.CLINICAL REC.	N 188		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137070	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 07/20/2006
NAME OF PROVIDER OR SUPPLIER CREST HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 101 IRONWOOD DR STE 230 COEUR D'ALENE, ID 83814		

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N 188	Continued From page 2 N188 05. Retention Period. Clinical records must be retained for five (5) years after the date of discharge, or in the case of a minor, three (3) years after the patient becomes of age. Policies provide for retention even if the HHA discontinues operations. Records must be protected from damage. This Rule is not met as evidenced by:	N 188		

HOME CARE Policies and Procedures Manual	SUBJECT: *Clinical Care - 485 Plan of Care/Plan of Treatment*	Policy No. 200.34 Effective Date: 10/10/96 Rev. 12/10/99; 3/8/01; 4/17/02, 07/10/03

PURPOSE:

1. To ensure that the agency *is in compliance* with all state and federal regulations regarding the implementation *and on-going evaluation* of a patient Plan of Care/Plan of Treatment (POC/POT)
2. To ensure the POC/POT is developed in consultation with agency staff

PROCEDURE:

1. The patient POC/POT is developed in consultation with the patient, the patient=s family, case manager and other clinical agency staff and turned into the office within 48 hours. The Director of Operations or Assistant Director of Operations will review the POC and the OASIS for accuracy and timeliness. The information will then be entered into the computer. The form will be signed by the RN, copied, placed in the patient chart and the original will be mailed to the physician for a signature. All forms mailed will be entered into the mailing log.
2. The patient POC/POT and all clinical services are implemented only in accordance with a physician and is established by a physician=s verbal order.
3. The patient POC will contain at least the following information:
   A. All pertinent diagnoses
   B. Mental status
   C. Types of services and equipment required
   D. Frequency and duration of visits
   E. Prognosis
   F. Potential for rehabilitation
   G. Functional limitations
   H. Activities permitted
   I. Nutritional requirements
   J. Medications and treatments
   K. Safety measures to protect against injury
   L. Instructions for timely discharge or referral
   M Statement of treatment goals
      N Instructions to patient and family
      O Food or drug allergies
      P Any other appropriate items
4. All drugs and treatments are administered by appropriate agency staff only as ordered by a physician on the POC/POT or on supplemental telephone orders as allowed by individual state regulations.
5. The POC/POT will be updated with changes in service provided, with any changes in the patient's condition and with each re-certification at least every 60 days.
6. Approved and signed within 30 working days (or sooner if required by individual state regulations) by the attending physician, dentist, podiatrist, or other licensed and legally authorized practitioner within his or her scope of practice.
7. All POC/POT are part of the patient record.

8. Modified and added to only within approval of the attending physician, dentist, podiatrist, or other licensed and legally authorized practitioner within his or her scope of practice.
9. The attending physician reviews the POC/POT every 60 days.
10. *Medicare patients will not be billed until the POT/POC is received in the office signed by the Physician. Services for Medicare patients will only be billed for when the Home Health Agency is acting upon a physicians certification that services are Medically Necessary and meet all Medicare requirements including Homebound.*
11. An abbreviated POT may be used for those patients receiving aide service only, to be completed by the RN Case Manager and updated with a new POT every 60 days.

Note: This policy and procedure applies to OIG risk areas #9, #10, #11, #12, #17 and #18 in Corporate Compliance Program.

HOME CARE Policies and Procedures Manual	SUBJECT: *Clinical Care – Recertification 485/Plan of Care /Plan of Treatment and OASIS Recertification Assessment*	Policy No. 200.38 Effective Date: 4/16/96 Rev: 12/10/99; 02/01/02

PURPOSE:

1. To ensure every patient on service is reviewed for certification.
2. To determine appropriateness of continuing home care service for the patient.
3. To determine adequacy of patient plans of care/plans of treatment (POC/POT).
4. To review utilization of disciplines, plans for discharge and update patient POC/POT.
5. To identify problems with continuity of care.
6. To ensure interdisciplinary team review of the POC/POT.
7. To ensure that established policies and procedures are followed in the provision of services.

PROCEDURE:

1. Patient 485's/POC/POT:
   A. Are to be reviewed a minimum of once every sixty-two (60) days for all patients that will be recertified.
      1. Adequacy of treatment plan
      2. Appropriateness of continuing health care services
   A. Will be completed two weeks prior to the recertification date.
   C. Are to be completed by the RN, Therapist or Case Manager representing appropriate components of the health care program.
   D. The person completing the 485/POC/POT will consult with the physician to obtain a verbal Start of Care/Start of Treatment (SOC/SOT).
2. Patient POC/POT are updated as appropriate.
3. Patient POC/POT for recertification/485 will include a written summary report (current status) of the patient's condition over the previous 60-days and is sent to the physician for signature.
4. The "Follow-up/Recertification Assessment", which includes OASIS questions as required by current Conditions of Participation, shall be done no earlier than the last 5 days of the episode. Once initiated, it must be completed within 48 hours.
5. The physician shall be notified in a timely manner, by phone and/or on a written communication report, regarding any changes in the patient's condition that occur between the completion of the 485 and the OASIS recertification assessment, which could necessitate changes in the patient's POC/POT. Any changes in treatment orders shall be documented on a Physicians Telephone Order signed by the attending physician.
6. The physician shall review all recert 485/Plans of Care to certify that the services are medically necessary and meet the requirements for coverage by Medicare.

HOME CARE Policies and Procedures Manual	SUBJECT: *Medical Records – Thinning of Patient Charts*	Policy No. 700.49/1 Effective Date: 7/10/98

POLICY: When patient charts are too full to neatly maintain the clinical record, the office staff will thin the charts.

PURPOSE:

1. To neatly maintain clinical documentation
2. To maintain thinned areas of the clinical record so they are securely stored and readily accessible

PROCEDURE:

1. When it becomes difficult to neatly maintain the patient's clinical record, the office staff will thin the clinical record. The components of the clinical record should be thinned with the following to remain in the chart:
   A. Telephone Orders – 2 certification periods
   B. SN notes – 2 months
   C. HHA notes – 2 months
   D. HHA Plan of Care – 2 certification periods
   E. Supervisory visits – 2 certification periods
   F. PT notes – 2 months
   G. ST notes – 2 months
   H. OT notes – 2 months
   I. MSW notes – 2 months
   J. Medication records – 2 certification periods
   K. Vital sign chart – 2 certification periods
   L. Blood sugar log – 2 certification periods
   M. Labs – 6 months
2. ***Do not*** thin the following:
   A. 485s
   B. SN evaluation
   C. PT evaluation
   D. OT evaluation
   E. MSW evaluation
   F. Admission intake form
3. The thinned items will be kept in the same order as the chart in a folder labeled with the patient name and start of care date. These thinned charts will be stored in a double-locked file that is easily accessible to office personnel.