DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
Seattle Regional Office
701 Fifth Avenue, Suite 1600, M/S RX-400
Seattle, WA 98104

CENTERS FOR MEDICARE & MEDICAID SERVICES

IMPORTANT NOTICE – PLEASE READ CAREFULLY

May 26, 2015

Vicki Salerno, Administrator
Care At Home
929 NW 16th Street
Fruitland, ID 83619

CMS Certification Number: 13-7068

Re: Conditions of Participation Met
Suspension of Payment Rescinded
Mandatory Termination Rescinded
Back in Substantial Compliance Effective April 20, 2015

Dear Ms. Salerno:

On May 12, 2015 a revisit survey was conducted at Care At Home by the Idaho Bureau of Facility Standards (State survey agency) to determine compliance with the Conditions of Participation required for Home Health Agencies (HHA). Findings from that revisit indicate that Care At Home has now achieved substantial compliance with Federal requirements for HHAs participating in the Medicare and Medicaid programs. Based on the State survey agency's findings and recommendation, **CMS is rescinding its termination action and the suspension of payment for new admissions effective April 20, 2015.**

If you have any questions regarding this letter, please contact Fe Yamada of my staff at 206-615-2381 or by email at marie.yamada@cms.hhs.gov.

Sincerely,

Patrick Thrift
Manager, Seattle Regional Office
Division of Survey & Certification

Cc: Idaho Bureau of Facility Standards
ID Medicaid
NGS

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – 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 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

May 21, 2015

Vicki Salerno, Administrator
Care At Home
929 Nw 16th Street
Fruitland, ID 83619-2256

RE: Care At Home, Provider #137068

Dear Ms. Salerno:

On May 12, 2015, a follow-up visit of your facility, Care At Home, was conducted to verify corrections of deficiencies noted during the survey of February 20, 2015.

We were able to determine that the Conditions of Participation of **Acceptance of Patients, POC, Med Super (42 CFR 484.18), Skilled Nursing Services (42 CFR 484.30) and Evaluation of the Agency's Program (42 CFR 484.52)** are now met. Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Also enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for inplementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the Home Health Agency into compliance, and that the Home Health Agency remains in compliance with the regulatory requirements;

- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567 and State Form 2567.

After you have completed your Plan of Correction, return the original to this office by **June 3, 2015**, and keep a copy for your records.

Thank you for the courtesies extended to the surveyors during their visit. If we can be of any help to you, please call us at (208) 334-6626, option 4.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/pmt
Enclosures
ec: Fe Yamada, CMS Region X Office

Care At Home

May 2, 2015

Sylvia Creswell, Co-Supervisor
Non-Long Term Care Section
Bureau of Facility Standards
P.O. Box 83720
Boise, ID 83720-0009

Dear Ms. Creswell

Enclosed please find our 2567 Plan of Correction for the follow-up survey dated May 12, 2015.

As requested, each item has been corrected and completion date provided.

If there are any questions regarding our plan please call us.

Thank you,

Vicki Salerno

Vicki Salerno,
Administrator
vsalerno@careathomehh.com
208-642-1838
208-880-1925 (cell)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137068	A. BUILDING _____ B. WING _____	R 05/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE AT HOME	929 NW 16TH STREET FRUITLAND, ID 83619

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 000}	INITIAL COMMENTS The following deficiencies were cited during the Medicare follow up survey of your agency from 5/11/15 to 5/12/15. The surveyors conducting the follow up were: Gary Guiles, RN, HFS, Team Leader Teresa Hamblin, RN, MS, HFS Acronyms used in this report include: CHF - Congestive Heart Failure MD - Medical Doctor OT - Occupational Therapy POC - Plan of Care PT - Physical Therapy RD - Registered Dietician RN - Registered Nurse SOC - Start of Care VAC - Vacuumm Assisted Closure. a treatment for wounds	{G 000}		
{G 157}	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the agency failed to ensure it was able to provide services to 1 of 7 patients (#4) who required PT services and whose records were reviewed. This resulted in the delay of treatment and increased the potential	{G 157}		

RECEIVED
JUN - 3 2015
FACILITY STANDARDS

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

Vicki Salerno, Admn. 6.2.15

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 157}	Continued From page 1 for complications. Findings include: Patient #4's medical record documented a 79 year old female whose SOC was 4/24/15. She was currently a patient as of 5/11/15. Her diagnosis was fractured pelvis. Patient #4's record contained a referral order from a local hospital dated 4/23/15 at 2:14 PM. The order showed it was faxed to the agency on 4/23/15. The order requested home health for PT services. The Administrator, interviewed on 5/11/15 beginning at 11:00 AM, stated RNs conducted the initial comprehensive assessment for all patients, regardless of the services that were ordered. Patient #4's record contained an initial assessment by the RN dated 4/24/15 beginning at 11:50 AM. The assessment stated Patient #4 had been in bed since her fracture. The assessment stated Patient #4 was chair fast and was unable to transfer herself. The assessment stated the RN told Patient #4 "...she needed to be up as much as tolerated to prevent complications." A PT evaluation was not documented until 4/29/15, 5 days after Patient #4's SOC. The Director of Therapy Services was interviewed on 5/12/15 beginning at 12:41 PM. She confirmed the referral order for PT services. She confirmed the delay in providing PT services to Patient #4. She stated the Physical Therapist only saw patients on Wednesday and Friday and was not available to provide services to Patient #4 until 4/29/15.	{G 157}	Action: All referrals will be reviewed by the HIM, DPS, and Therapy manager to assure that the HHA can meet the clients needs in a timely manner. Nursing educated on the need to make contact with the therapist to confirm that the opening OASIS is complete. Description: This review will ensure that the HHA has the needed services available and that the referral source can be alerted in a timely manner for the need to explore alternate placement of a client. Contact between nursing and therapy will ensure that any delays can be communicated. Compliance date: 6/3/15 Monitoring: Health information manager will recieve initial referral and it will be passed on to the Director of Professional services for staffing of Nursing. Therapy director will be contacted if there is a question on availability of a therapist.	

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{G 157}	Continued From page 2 The agency accepted Patient #4 for treatment without the ability to provide that treatment in a timely manner.	{G 157}	Action: HHA agency's procedure is to perform a nutritional evaluation with the opening OASIS. If the client scores in the high risk area based on the questions on the assessment the client is then referred to our dietitian for phone consultation to assist with dietary needs. This action continues. Description: This action ensures that any dietary needs are evaluated and the proper education is given to the client to assist with needs. Assessment was performed on client and referred to the Dietitian. The nurse and the Dietitian both evaluated the client for her nutrition at risk and the interventions that the client and her spouse had in place. Client and spouse were both aware of the need for nutrition and were using ensure to assure that her weight loss did not occur again. Dietitian found client's plan to be appropriate and there were no further interventions needed. Nursing also felt that client was stable in her weight and was aware of the need to maintain her nutrition. Date of Compliance: Care at Home already had this process in place and will continue. Monitoring: Director of Professional Services or Assistant Director will assure that a copy of the nutritional assessment is placed for the Dietitian to review. Dietitian will perform a phone consultation. And coordinate with nursing.	
{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 medical record review and staff interview, it was determined the agency failed to ensure relevant monitoring was included in the plan of care for 1 of 9 patients (#9) whose records were reviewed. This resulted in the failure to monitor patient weight. It had the potential to result in missed relevant clinical findings. Findings include: 1. Patient #9 was an 81 year old female who was admitted to the agency on 4/27/15 after surgery for a hip fracture. An RN assessment, titled "nutritional screening," dated 4/27/15, documented an assessment of "high" nutritional risk. Factors influencing nutritional risk were identified as: 1) significant weight loss in the prior year; 2) an inability to physically shop or cook; and 3) 5 or more daily	{G 159}		

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{G 159}	Continued From page 3 medications. An RN communication note to the physician, dated 4/27/15 and titled "Physician Interim Order," was reviewed. It documented "Patient experineced significant weight loss of 25 lbs, but is gaining most of the weight back." An RD note, "Nutition Assessment," dated 4/28/15, documented a current reported weight of 123 pounds. The note documented Patient #9's had regained most of the 25 pound weight loss. The POC, for certification period 4/27/15 to 6/25/15, was reviewed. It did not include monitoring of Patient #9's weight or nutritional status. RN visit notes were reviewed for 4/27/15, 4/29/15, 5/1/15, and 5/11/15. There was no documentation of Patient #9's weight on 4/29/15, 5/1/15, or 5/11/15. The Director of Professional Services was interviewed on 5/12/15 at 10:45 AM. She confirmed Patient #9 was assessed to be at high nutritional risk, had a history of recent weight loss, and that monitoring weight was not included on the POC. The POC did not include monitoring Patient #9s weight and nutritional status.	{G 159}		
{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.	{G 164}		

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{G 164}	Continued From page 4 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the agency failed to ensure staff promptly alerted the physician to significant clinical findings in 1 of 9 patients (#3) whose medical records were reviewed. This resulted in missed opportunities for the physician to review the findings and adjust the POC. Findings include: Patient #3 was a 69 year old male who was admitted to the agency on 4/20/15 for care related to chronic obstructive pulmonary disease. Secondary diagnoses included hemiplegia, chronic pain, congestive heart failure, coronary atherosclerosis, hypertension, and acute alcoholism. Patient #3's POC, for certification period 4/20/15 to 6/18/15, directed nursing staff to assess Patient #3's cardiopulmonary status and educate Patient #3 in CHF management including daily weights and when to report weight changes to MD. Specific reporting parameters for weight changes were not included in the POC. Patient #3's medical record included patient education material "Heart Failure Symptom Awareness and Action Plan." It provided patient instructions to "see your doctor now" if you have weight changes of more than 5 pounds over or under normal weight." SN notes were reviewed. The records documented Patient #3's weights as follows: 4/20/15 - 168.00 pounds (reported) 4/24/15 - 171.00 pounds (actual using the	{G 164}	Action: Nursing was educated on documenting the explanation of discrepencies with weights or vitals between equipment. In the event that there is an actual descrepancy the MD would be notified. Nursing educated to send an interim order to the MD regardless. Description: Performing documentation will assist that the record is accurate and that the information collected is correct. Notifying the MD will assure that he is aware of the discrepancy and what client's weight record showed. This client was keeping his own weight record starting on 4/25/15 performing his weights the way he was educated by the RN. He was doing his weights first things in the AM after voiding with his night clothes still on. Case Manager reported to surveyor that client began his record that next day and that she could obtain it. Case Manager also wrote late entry documentation to assist to complete the chart. Compliance date: June 3, 2015. Action: DPS or ADPS will monitor nursing interventions to ensure that discrepencies are being addressed by the Case Management RN .	

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{G 164}	Continued From page 5 agency's scale) 4/28/15 - 161.20 pounds (actual using the client's scale) 5/01/15 - 161.80 pounds (actual using the client's scale) There was a difference of 9.80 pounds between the visits on 4/24/15 and 4/28/15. There was no documentation to indicate the physician had been alerted to Patient #3's weight changes. The Assistant Director of Professional Services was interviewed on 5/11/15 at 1:20 PM. When asked if the agency had a policy related to reporting parameters for weight changes in patients with CHF, she stated there was no specific policy, it depended on physician ordered parameters. She reviewed Patient #3's record and confirmed weight reporting parameters were not included on the POC and that there was no documentation the weight change of 9.8 pounds had been reported to the physician. The RN who conducted home visits for Patient #3 was interviewed on 5/12/15 at 10:15 AM. She stated Patient #3 was wearing cowboy boots on 4/24/15 and the weight may not have been accurate. She stated Patient #3 did not have his own scale at SOC but obtained one on or before the skilled nursing visit on 4/28/15. She stated Patient #3's record of weights showed less than a one pound change. She did not recall when Patient #3 got a scale and started monitoring his own weights. Agency staff did not report Patient #3's 9 pound change in weight.	{G 164}		
{G 176}	484.30(a) DUTIES OF THE REGISTERED	{G 176}		

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{G 176}	Continued From page 6 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 medical record review and staff interview, it was determined the agency failed to ensure clinical notes documented coordination of care activities in 2 of 9 patients (#1 and #2) whose records were reviewed. This resulted in a lack of clarity regarding the actual course of care. It had the potential to interfere with quality and continuity of patient care. Findings include: 1. Patient #1 was a 39 year old male who was admitted to the agency on 3/14/15 for care related to insulin-dependent diabetes and wound care. Physician orders, dated 4/17/15, for "V.A.C. wound care" directed nursing staff to change the dressing on Patient #1's left thigh 3 times per week for 30 days. There was subsequent nursing documentation of dressing changes on 4/20/15, 4/22/15, and 4/24/15. A "Discharge Summary," dated 4/29/15, indicated Patient #1 was discharged from services on 4/27/15 due to returning to work. There was no documentation of coordination of care to show how this information had been determined. The Assistant Director of Professional Services was interviewed on 5/11/15 at 11:05 AM. She stated there was communication with the wound	{G 176}	Action: Nursing was educated to include all details on a discharge summary when a phone call to DC is received, and to make a phone contact with therapist if a client cannot be reached to see if the therapist is having the same issue. Description: This education will ensure that the medical record is complete and that the client is seen as soon as possible. Compliance Date: June 3, 2015 Monitoring: DPS, or ADPS will monitor all discharge summaries and discharged charts to ensure that all proper communications are documented. DPS will monitor openings with delay dues to inability to contact patient to ensure the timeliness of open and communication between PT and RN.	

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{G 176}	Continued From page 7 care clinic about Patient #1 no longer requiring services due to the plan to return to work. She confirmed there was no specific documentation regarding this coordination of care. Coordination of care between the agency and the wound care clinic related to Patient #1 was not documented. 2. Patient #2's medical record documented a 69 year old female whose SOC was 4/03/15. Her diagnosis was chronic obstructive pulmonary disease. She was currently a patient as of 5/11/15. Patient #2's POC for the certification period 4/03/15-6/01/15 stated she was to receive nursing, PT, and OT services. A transfer summary, dated 4/20/15, stated Patient #2 was hospitalized on 4/14/15 for respiratory distress. Patient #2 was hospitalized for 6 days and was discharged on 4/20/15. A "Physician Interim Order" by the RN, dated 4/23/15, stated Patient #2's resumption of care was delayed until 4/23/15 because the RN was not able contact Patient #2 via telephone. However, "Communication Notes" by the Physical Therapist, dated 4/21/15 but not timed, stated the therapist had arrived at Patient #2's house on 4/21/15 for a scheduled visit. The note stated Patient #2 told the therapist an RN visit had not been conducted to resume care. This prevented the therapist from treating Patient #2 and the visit was canceled. No documentation was present that the RN coordinated her visit with the therapist.	{G 176}		

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{G 176}	Continued From page 8 The Director of Professional Services was interviewed on 5/11/15 beginning at 10:43 AM. She stated she did not know why the PT visit was delayed. She reviewed Patient #2's record and said she could not find documentation that the RN coordinated visits with the therapist. The RN failed to coordinate services with the therapist	{G 176}		

Bureau of Facility Standards

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	OAS001080	A. BUILDING: _____ B. WING _____	R 05/12/2015

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{N 000}	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the Idaho state licensure follow up survey of your agency from 5/11/15 to 5/12/15. The surveyors conducting the follow up were: Gary Guiles, RN, HFS, Team Leader Teresa Hamblin, RN, MS, HFS	{N 000}	RECEIVED JUN - 3 2015 FACILITY STANDARDS	
N 092	03.07024.01. SK.NSG.SERV. N092 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: This Rule is not met as evidenced by: Refer to G176.	N 092	Please refer to G176	
{N 098}	03.07024. SK. NSG. SERV. N098 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: f. Informs the physician and other personnel of changes in the patient's condition and needs; This Rule is not met as evidenced by: Refer to G164.	{N 098}	Please refer to G164	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Vicki Salerno — TITLE: Adm. — (X6) DATE: 6.2.15

Bureau of Facility Standards

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{N 151}	03.07030.PLAN OF CARE N151 030. PLAN OF CARE. Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's plan of care. This Rule is not met as evidenced by: Refer to G157.	{N 151}	Please refer to G 157	
N 153	03.07030.PLAN OF CARE N153 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: a. All pertinent diagnoses; This Rule is not met as evidenced by: Refer to G159.	N 153	Please refer to G 159	