



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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RICHARD M. ARMSTRONG – Director

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DIVISION OF LICENSING & CERTIFICATION  
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July 8, 2016

**CERTIFIED MAIL: 7012 3050 0001 2125 5716**

Melinda Williams, Administrator  
Intermountain Home Care Of Cassia  
1031 E Main Street  
Burley, ID 83318-2029

RE: Intermountain Home Care Of Cassia, Provider #137016

Dear Ms. Williams:

On June 23, 2016, a follow-up visit of your facility, Intermountain Home Care Of Cassia, was conducted to verify corrections of deficiencies noted during the survey of April 18, 2016.

We were able to determine that the Conditions of Participation of **Organization, Services & Administration (42 CFR 484.14)**, **Group of Professional Personnel (42 CFR 484.16)** and **Evaluation of Agency's Program (42 CFR 484.52)** are now met.

We have determined that Intermountain Home Care Of Cassia continues to be out of compliance with the Medicare Conditions of **Participation of Acceptance of Patients, POC and Med Supervision (42 CFR 484.18)**.

In our letter to you dated April 29, 2016, we stated: "failure to correct the deficiencies and achieve compliance will result in our recommending that the Centers for Medicare and Medicaid Services (CMS) Region X Office, Seattle, Washington, terminate your approval to participate in the Medicare program."

Because of your failure to correct, we have made the recommendation that CMS continue with the alternative sanctions, as noted in our letter dated April 29, 2016, which included CMP and Termination on October 18, 2016 if correction of the deficiencies were not made prior to that date.

Melinda Williams, Administrator  
July 8, 2016  
Page 2 of 2

CMS will be in contact with you regarding the procedures, timelines, and appeal rights associated with this recommendation that must be followed.

Enclosed is your copy of a Post-Certification Revisit Report (CMS-2567B), listing deficiencies that have been corrected.

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 implementing 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 **July 18, 2016**, and keep a copy for your records.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

*Dennis Kelly*  
*on behalf of*

SUSAN COSTA  
Health Facility Surveyor  
Non-Long Term Care

*Dennis Kelly RN*

DENNIS KELLY, RN  
Co-Supervisor  
Non-Long Term Care

SC/pmt

Enclosures

cc: Manual Bravo, CMS Region X Office

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

PRINTED: 07/07/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137016	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R 06/23/2016
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NAME OF PROVIDER OR SUPPLIER  INTERMOUNTAIN HOME CARE OF CASSIA	STREET ADDRESS, CITY, STATE, ZIP CODE 1031 E MAIN STREET BURLEY, ID 83318
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{G 000}	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare follow-up survey of your agency from 6/22/16 to 6/23/16. The surveyors conducting the follow-up survey were:</p> <p>Susan Costa, RN, HFS Teresa Hamblin, RN, MS, HFS Kristin Inglis, RN, HFS Nancy Bax, RN, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>ADL - Activities of Daily Living BG - Blood Glucose CHF - Congestive Heart Failure COPD - Chronic Obstructive Pulmonary Disease DM - Diabetes Mellitus DME - Durable Medical Equipment EMR - Electronic Medical Record ER - Emergency Room f/u - follow up HHA - Home Health Agency HTN - Hypertension LPM - Liters per Minute MRSA - Methicillin-Resistant Staphylococcus Aureus (A bacteria that has become resistant to many antibiotics) OASIS - Outcome and Assessment Information Set OT - Occupational Therapy PEG - Percutaneous Endoscopic Gastrostomy (a feeding tube inserted through the abdominal wall into the stomach to provide a means of feeding when oral intake is not adequate) POC - Plan of Care pt - Patient PT - Physical Therapy</p>	{G 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melinda Williams RN TITLE: Nurse Administrator (X6) DATE: 7/8/16

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 000}	Continued From page 1 pta/PTA - Physical Therapy Assistant RN - Registered Nurse ROC - Resumption of Care SN - Skilled Nursing SOC - Start of Care UTI - Urinary Tract Infection WNL - Within Normal Limits	{G 000}		
{G 143}	<p>484.14(g) COORDINATION OF PATIENT SERVICES</p> <p>All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>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 care coordination for 1 of 10 patients (Patient #6) whose records were reviewed. This interfered with quality, safety and continuity of patient care. Findings include:</p> <p>Patient #6 was a 59 year old female admitted to the agency on 5/12/16 for SN and PT services related to CHF. Additional diagnoses included COPD, lupus and HTN. Her record, including the POC, for the certification period 5/12/16 to 7/10/16, was reviewed.</p> <p>Patient #6's record included an ROC comprehensive assessment dated 6/13/16 and signed by RN D, her Case Manager. The assessment stated Patient #6 was admitted to the hospital with a diagnosis of heart failure, and was discharged from the hospital on 6/11/16.</p>	{G 143}	<p>G 143 Action Plan:</p> <ol style="list-style-type: none"> <li>1. Nurse Administrator will educate the staff on when and how to report a change in condition, whom to report it to (physician, case manager, Interdisciplinary Team members involved), and the expectation of documentation. This will ensure staff understanding of expectations and knowledge deficits.</li> <li>2. Nurse Administrator will ensure care coordination meetings occur, which include a review of patient visits from the previous day and/or patient concerns on the upcoming day's schedule. This will ensure coordination of care has occurred. Care coordination meeting will occur Monday through Friday for three months and then weekly.</li> </ol> <p>Monitoring &amp; Tracking of Compliance:</p> <ol style="list-style-type: none"> <li>1. Nurse Administrator will ensure education is documented and that 100% of staff receive education.</li> <li>2. Nurse administrator or designee ensures documentation in the medical record reflects changes made during care coordination meetings.</li> <li>3. Quality Director will randomly audit 75% of charts to ensure that documentation of coordination has occurred at 90% compliance. When 90% compliance is achieved for 4 months, 10% of charts based on average daily census will be randomly audited per quarter.</li> </ol>	8/19/16

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{G 143}	<p>Continued From page 2</p> <p>Patient #6's record included a physician order taken on 6/14/16, and signed by RN D. The order included "Evaluate/Instruct patient/caregiver in weighing daily, recording weight, notifying physician for weight gain greater than 2 pounds in one day or 5 pounds over target weight."</p> <p>Patient #6's record included an SN visit note dated 6/17/16 and signed by RN E. The note documented a weight gain of 7 pounds since her last SN visit on 6/13/16. The note did not document communication of Patient #6's weight gain to her physician or her RN Case Manager.</p> <p>During an interview on 6/23/16 at 10:05 AM, RN D stated RN E did not inform her or Patient #6's physician of her 7 pound weight gain in 4 days.</p> <p>The agency failed to ensure a change in Patient #6's condition was communicated to her physician and Case Manager.</p> <p>G 145 484.14(g) COORDINATION OF PATIENT SERVICES</p> <p>A written summary report for each patient is sent to the attending physician at least every 60 days.</p> <p>This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the agency failed to ensure a written summary report of care provided and patient progress was sent to the attending physician at least every 60 days for 2 of 4 patients (#2 and #3) who received home health services for more than 1 certification period and whose records were reviewed. This had the potential to result in decreased physician</p>	{G 143}	<p>G 145 Action Plan:</p> <ol style="list-style-type: none"> <li>1. Nurse Administrator will educate 100% of the nursing and therapy staff to the 60 day summary standard and the documentation requirements. This will ensure clear understanding for accurate and updated 60 day assessments.</li> <li>2. Nurse Administrator will ensure all recerts are discussed in the care coordination meeting and that there is an accurate and updated 60 day summary.</li> </ol> <p>Monitoring and tracking for compliance:</p> <ol style="list-style-type: none"> <li>1. Nurse Administrator will ensure education is documented and that 100% of staff receive education.</li> <li>2. Quality Director or designee will audit 100% of re-certifications to ensure they include an updated 60 day summary. Will monitor for 4 months to assure 100% compliance then random sampling of 10% of charts to assure expectations are met monthly.</li> </ol>	8/19/16

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G 145	<p>Continued From page 3</p> <p>awareness of patient conditions and reduce the quality of patient care. Findings include:</p> <p>1. Patient #3 was a 7 year old female who was admitted to the agency on 1/17/11, for SN and PT services related to chromosomal abnormalities and an ear infection. Her record, including POCs, for the certification periods 4/20/16 to 6/18/16 and 6/19/16 to 8/17/16, was reviewed.</p> <p>Patient #3's POC dated 6/19/16 to 8/17/16, included a 60 day summary to the physician. The summary matched the prior certification period summary verbatim. It was not updated to reflect her progress towards goals, and care that was provided during the previous 60 days.</p> <p>During an interview on 6/23/16 beginning at 8:50 AM, the Administrator of Intermountain Home Health reviewed Patient #3's record. She confirmed the 60 day summary on both POC's were the same. She stated the current 60 day summary was not accurate to reflect Patient #3's nursing assessment performed on 6/16/16.</p> <p>The agency did not ensure Patient #3's physician received an accurate and updated 60 day assessment.</p> <p>2. Patient #2 was a 68 year old male admitted to the agency on 1/22/16 for SN, PT, OT and aide services related to abnormality of gait. Additional diagnoses included heart failure, DM, and 3 pressure ulcers. His record, including the POC, for the certification period 5/21/16 to 7/19/16, was reviewed.</p> <p>Patient #2's record, reviewed on 6/22/16, did not include a written summary report for his previous</p>	G 145		

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G 145	Continued From page 4 certification period, which ended on 5/20/16.  During an interview on 6/23/16 at 11:25 AM, the Administrator of Intermountain Home Health stated 60 day summaries were included on the POC for the subsequent certification period, which was sent to the physician for signature. She reviewed Patient #2's POC for the certification period 5/21/16 to 7/19/16 and stated it did not include a summary of his care and progress during the previous certification period.  The agency failed to ensure Patient #2's physician received a summary report for each certification period.	G 145		
{G 156}	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER  This CONDITION is not met as evidenced by: Based on medical record review, and staff interview, it was determined the agency failed to ensure care was provided in accordance with patients' POCs, the POCs included all pertinent information, the physician was notified of changes in patients' conditions, and physician verbal orders were taken and documented appropriately. This resulted in unmet patient needs and care provided without physician authorization. Findings include:  1. Refer to G158 as it relates to the failure of the agency to ensure care was provided in accordance with patients' POCs.  2. Refer to G159 as it relates to the failure of the	{G 156}	Refer to G 158, G 159, G 164, and G 166	

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{G 156}	Continued From page 5 agency to ensure patients' POCs included all pertinent information.  3. Refer to G164 as it relates to the failure of the agency to notify the physician of changes in patients' conditions.  4. Refer to G166 as it relates to the failure of the agency to ensure verbal orders were put into writing.  The cumulative effect of these negative systemic practices seriously impeded the ability of the agency to provided quality care in accordance with established POCs.	{G 156}		
{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 record review and staff interview, it was determined the agency failed to ensure care followed a physician's written POC for 2 of 10 patients (#2 and #7) whose records were reviewed. This resulted in unauthorized treatments, as well as, omissions of care and unmet patient needs. Findings include:  1. Patient #2 was a 68 year old male admitted to the agency on 1/22/16 for SN, PT, OT and aide services related to abnormality of gait. Additional diagnoses included heart failure, DM, and 3 pressure ulcers. His record, including the POC, for the certification period 5/21/16 to 7/19/16, was	{G 158}	G 158 Action Plan: 1. Nurse Administrator will educate 100% of the staff that no services can be performed without a physician order, all physician orders must be performed, and all orders must be reviewed before every visit. Teaching will include entering orders the day they are received, including discontinuation of treatments, adding medications, and discontinuing medications. This will ensure clear understanding for following physician orders. 2. Nurse Administrator will ensure all interventions performed are discussed in the care coordination meeting and that there is an order for the intervention. This will ensure that clinicians are following the written plan of care. Monitoring and tracking for compliance: 1. Nurse Administrator will ensure education is documented and that 100% of staff receive education. 2. Nurse Administrator or designee will perform 6 shared visits per employee with an accompanying chart audit for shared visit patients in 2016 to ensure that orders are present for interventions performed during the visit. Shared visits will then continue quarterly.	8/19/16

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{G 158}	<p>Continued From page 6 reviewed.</p> <p>Patient #2's record included a physician's verbal order taken on 5/19/16, and signed by the Physical Therapist. It stated "Nurse visit to administer testosterone injection every 3 weeks, next due week of 5/24/16." Patient #2's record included an SN visit note dated 5/23/16, signed by RN A. The note did not document a testosterone injection was administered. The next SN visit was documented on 6/16/16.</p> <p>During an interview on 6/23/16 at 11:25 AM, the Administrator of Intermountain Home Health reviewed Patient #2's record and confirmed the 5/24/16 SN visit note did not document administration of a testosterone injection. She stated there was no documentation of administration of a testosterone injection during the week of 5/24/16.</p> <p>Patient #2 did not receive an injection as ordered by his physician.</p> <p>2. Patient #7 was a 53 year old male admitted to the agency on 5/11/16 for SN and PT services related to urinary retention. Additional diagnoses included urinary tract infection, constipation, hypoxemia, syncope, collapse, and pneumonia. His record, including the POC, for the certification period 5/11/16 to 7/09/16, was reviewed.</p> <p>a. Patient #7's POC included an order for continuous oxygen at 2 LPM. There were no updates or changes to this medication order included in Patient #7's medical record. SN visit notes for 6/01/16 and 6/07/16 documented Patient #7 was using oxygen continuously at 3 LPM. There was no documentation to indicate</p>	{G 158}			

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{G 158}	<p>Continued From page 7</p> <p>Patient #7 was re-instructed on the dose that was ordered by the physician.</p> <p>b. Patient #7's record included a SN visit note, dated 6/07/16, stated "This nurse removed [foley] catheter pt reports he is supposed to arrive at dr visit today with full bladder." There was no documentation stating authorization was obtained from his physician prior to removing the foley catheter.</p> <p>c. Patient #7's POC included an initial order for a PT evaluation, followed by a subsequent order, dated 5/27/16, for PT visits two times per week for 4 weeks for "strengthening, gait and balance program, [and] to improve safe independent dynamic mobility." The record indicated 1 PT visit was provided per week for 3 weeks, for the weeks beginning on 5/29/16, 6/05/16, and 6/12/16. There was no documentation to indicate missed PT visits were reported to the physician.</p> <p>During an interview on 6/23/16 at 8:54 AM, the Director of Quality reviewed Patient #7's record. She stated PT visits were made 1 time per week rather than twice a week as ordered, and she did not see documentation of physician notification of the missed visits. She also stated she did not see a physician's order to remove Patient #7's foley catheter. She stated they should have range orders for the oxygen to allow variance in the amount of oxygen use allowed.</p> <p>Care related to PT frequency, oxygen use, and foley catheter removal did not follow the written plan of care for Patient #7.</p>	{G 158}		
{G 159}	484.18(a) PLAN OF CARE	{G 159}		

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{G 159}	<p>Continued From page 8</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the agency failed to ensure the POC covered all services provided, equipment required, or other appropriate items in 6 of 10 patients (#1, #2, #3, #4, #5, and #10) whose records were reviewed. This had the potential to negatively impact quality and coordination of patient care. Findings include:</p> <p>1. Patient #2 was a 68 year old male admitted to the agency on 1/22/16 for SN, PT, OT and aide services related to abnormality of gait. Additional diagnoses included heart failure, insulin dependent DM, and 3 pressure ulcers. His record, including the POC, for the certification period 5/21/16 to 7/19/16, was reviewed.</p> <p>Patient #2's POC did not include all information pertinent to his care. Examples include:</p> <p>a. Patient #2's POC for the certification period 5/21/16 to 7/19/16 included primary and other pertinent diagnoses. His diagnoses included 3 pressure ulcers.</p> <p>Patient #2's record included an OT recertification</p>	{G 159}	<p>G 159 Action Plan:</p> <ol style="list-style-type: none"> <li>1. Nurse Administrator will educate 100% of the staff on plan of care development. This will ensure clear understanding for plan of care development.</li> <li>2. Quality Director will audit all admissions. They will audit POC for charting of mental status, service type, equipment, supplies, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional status, medications, treatments, safety measures, pertinent diagnosis, and discharge referral needs. This will ensure that all POCs are complete and accurate.</li> </ol> <p>Monitoring and tracking for compliance:</p> <ol style="list-style-type: none"> <li>1. Nurse Administrator will ensure education is documented and that 100% of staff receive education.</li> <li>2. Quality Director or designee will audit 100% of all admissions and resumptions of care (ROC) with 90% accuracy based on the POC audit tool. Will monitor for 4 months to assure 90% accuracy is maintained, then 10% will be monitored for each clinician monthly.</li> </ol>	8/19/16

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{G 159}	<p>Continued From page 9</p> <p>comprehensive assessment visit note dated 5/20/16, signed by the Occupational Therapist. The assessment stated "Patient has no pressure ulcers."</p> <p>During an interview on 6/23/16 at 11:25 AM, the Administrator of Intermountain Home Health reviewed Patient #2's record and stated he had stage II pressure ulcers during a previous certification period. She stated the pressure ulcers were healed and should not be included as diagnoses on the POC for the certification period 5/21/16 to 7/19/16.</p> <p>b. Patient #2's record included an SN visit note dated 5/21/16, signed by RN B. The note stated Patient #2 used continuous oxygen at 4 liters per minute. His POC did not include oxygen or the equipment used to deliver his oxygen.</p> <p>c. Patient #2's record included an SN visit note dated 5/23/16, signed by RN A. The note stated Patient #2's wife checked his BG level every morning. His POC did not include equipment used to check his BG level.</p> <p>d. Patient #2's record included a PT evaluation visit note dated 5/20/16, signed by the Physical Therapist. The note stated Patient #2 was incontinent and used a condom catheter. His POC did not include a condom catheter.</p> <p>e. Patient #2's record included an OT recertification visit note dated 5/20/16, signed by the Occupational Therapist. The note documented equipment used by Patient #2 in his home, including a chair lift, bedside commode and grab bars. Patient #2's POC did not include a chair lift, bedside commode or grab bars.</p>	{G 159}		
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{G 159}	<p>Continued From page 10</p> <p>During an interview on 6/23/16 at 11:25 AM, the Administrator of Intermountain Home Health reviewed Patient #2's record and stated his oxygen and oxygen equipment, BG monitor, chair lift, bedside commode and grab bars should be included on his POC.</p> <p>Patient #2's POC included diagnoses that were not pertinent to his care. Additionally, his POC did not include all supplies and equipment used in his home.</p> <p>2. Patient #5 was a 60 year old male admitted to the agency on 6/17/16 for SN services related to bilateral lower extremity stasis ulcers and cellulitis. Additional diagnoses included HTN, asthma and depression. His record, including the POC, for the certification period 6/17/16 to 8/15/16, was reviewed.</p> <p>Patient #5's POC did not include all information pertinent to his care. Examples include:</p> <p>a. Patient #5's record included an SN SOC comprehensive assessment dated 6/17/16 and signed by the RN Nurse Administrator. The assessment stated Patient #5's physician was contacted during the visit to obtain wound care orders, and wound care was provided during the SOC visit. Patient #5's POC did not include wound care orders. Additionally, his POC did not include wound care supplies.</p> <p>During an interview on 6/23/16 at 10:55 AM, the Nurse Administrator reviewed the record and stated she contacted Patient #5's physician during the SOC visit to obtain wound care orders. She confirmed she did not add the wound care</p>	{G 159}		
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{G 159}	<p>Continued From page 11 orders or supplies to Patient #5's POC.</p> <p>Patient #5's POC was not complete to include orders or supplies for his wound care.</p> <p>b. Patient #5's POC included orders for 1 SN visit on 6/17/16, and 2 SN visits per week for 5 weeks, effective 6/17/16. Three SN visits were ordered for the week of 6/17/16. His record included an SN visit on 6/17/16. No additional SN visits were documented that week.</p> <p>During an interview on 6/23/16 at 10:55 AM, the Nurse Administrator reviewed Patient #5's record. She stated she performed his SOC visit and created the orders on his POC. She stated the SN visit orders were written incorrectly and confirmed Patient #5 did not receive SN visits as ordered on his POC.</p> <p>Patient #5's POC did not include accurate frequency of SN visits.</p> <p>3. Patient #10 was a 93 year old female admitted to the agency on 5/23/16 for SN, PT and aide services following surgical repair of her hip fracture. Additional diagnoses included DM and HTN. Her record, including the POC, for the certification period 5/23/16 to 7/21/16, was reviewed.</p> <p>Patient #10's POC did not include all information pertinent to his care. Examples include:</p> <p>a. Patient #10's POC included continuous oxygen at 1 liter per minute. His POC did not include supplies or equipment to deliver his oxygen.</p>	{G 159}		

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{G 159}	<p>Continued From page 12</p> <p>b. Patient #10's POC included a note stating her physician was contacted by RN D during her SOC visit. The note stated her physician ordered an antibiotic. Patient #10's POC did not include an antibiotic.</p> <p>c. Patient #10's POC included a note stating her blood glucose level was checked the morning of her SOC visit. Her POC did not include equipment used to check her BG level.</p> <p>During an interview on 6/23/16 at 11:10 AM, the Administrator of Intermountain Home Health reviewed Patient #10's record and stated her oxygen and blood glucose monitoring supplies should be included on her POC. Additionally, she confirmed the antibiotic ordered during her SOC visit should be included on her POC.</p> <p>Patient #10's POC did not include all pertinent supplies and medications.</p> <p>4. Patient #4 was a 2 year old male admitted to the agency on 10/08/14 for SN and PT services related to achondroplasia, a form of dwarfism. An additional diagnosis included bronchopulmonary dysfunction. His record, including the POC, for certification period 3/31/16 to 5/29/16, was reviewed.</p> <p>Patient #4's POC did not include all information pertinent to his car. Examples include:</p> <p>a. The section of the POC, "DME and Supplies," included oxygen. The intervention orders included SN visits, as needed "for complications of oxygen administration." There were no medication orders for oxygen on Patient #4's POC, that specified whether oxygen was to be used on a</p>	{G 159}			

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{G 159}	<p>Continued From page 13</p> <p>continuous or intermittent basis, or the LPM range.</p> <p>b. A PT visit note, dated 6/01/16, documented equipment used during the visit, including a guardian walker with seat-handgrips. The equipment was not listed on the POC.</p> <p>During an interview on 6/23/16 at 8:35 AM, the Director of Quality confirmed the findings. She stated it appeared Patient #4 was on oxygen and she did not see any specific oxygen orders included on the POC. She stated the walker was not listed on the POC and she did not know why.</p> <p>Patient #4's POC did not include oxygen orders or relevant DME.</p> <p>5. Patient #1 was a 68 year old female admitted to the agency on 6/11/16, for SN, PT, and OT services related to wound care and metastasis of breast cancer. Additional diagnoses included a history of falling and malignant neoplasm. Her record, including the POC for the certification period 6/11/16 to 8/09/16, was reviewed.</p> <p>Patient #1's POC did not include all information pertinent to her care. Examples include:</p> <p>a. Patient #1's chart included an "RN ADMIT" note, dated 6/11/16, and signed by the admitting RN. Patient #1's pain was noted as generalized at a level "6". Her pain was rated on a 1-10 scale, with 10 being the worst pain. Patient #1 was asked what the pain prevented her from doing, and she stated "almost everything when not medicated." Additionally, she had pain of a level "2" in her left arm related to her cancer and lymphedema. Patient #1's POC included no</p>	{G 159}		
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{G 159}	<p>Continued From page 14 Interventions or goals related to her pain.</p> <p>b. Patient #1's chart contained orders dated 6/13/16, verified by her Physician, to instruct her on her diet. Her POC did not list her nutritional requirements.</p> <p>During and interview on 9/22/16 at 9:10 AM, the agency's Nurse Administrator confirmed the findings. She stated that Patient #1's POC did not include interventions and goals for pain, or nutritional requirements.</p> <p>Patient #1's POC did not include interventions and goals for pain, or nutritional requirements.</p> <p>6. Patient #3 was a 7 year old female who was admitted to the agency on 1/17/11, for SN and PT services related to chromosomal abnormalities and ear infection. Her record, including the POC, for the certification period 6/19/16 to 8/17/16, was reviewed.</p> <p>Patient #3's POC was not updated, complete and comprehensive as follows:</p> <p>a. Patient #3 had a PEG feeding tube. Her recertification assessment dated 6/16/16, stated she continued to receive nutritional supplementation via her PEG tube.</p> <p>b. Patient #3's POC included documentation she was on continuous oxygen by nasal cannula. Her POC also included a 60 day summary that stated she was on oxygen at night, and was placed on oxygen during the day if her saturations dropped below 86%. Patient #3's POC did not include oxygen supplies, a portable oxygen supply or a pulse oximeter.</p>	{G 159}		
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{G 159}	<p>Continued From page 15</p> <p>c. Her POC included a topical medication called Nystatin. However, the POC did not include where the medication was to be applied.</p> <p>d. Patient #3's POC documented her primary diagnosis was otitis media, (an ear infection). The recertification assessment, completed on 6/16/16, by the RN Case Manager, did not document an assessment of Patient #3's ears. Additionally, the recertification assessment did not include documentation of an ear infection.</p> <p>e. Patient #3's POC included the following goals, with a target of "Within 2 weeks." Her POC for the previous certification period included the same goals, as follows:</p> <p>i. "Caregivers will demonstrate compliance with treatment plan, diet, meds, exercise, other."</p> <p>ii. "Patient/caregiver will demonstrate knowledge of disease process, treatment goals and self-care management."</p> <p>f. Patient #3's POC included additional goals, with a target of "Within 2 visits," as follows:</p> <p>i. "Patient/caregiver will demonstrate effective disease management practices."</p> <p>ii. "Patient/caregiver will verbalize s/s [signs/symptoms] to report to RN or physician."</p> <p>During an interview on 6/23/16 beginning at 8:50 AM, the Administrator of Intermountain Home Health reviewed Patient #3's record. She compared the POCs for 4/20/16 to 6/18/16 and 6/19/16 to 8/17/16. The Administrator of</p>	{G 159}		
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{G 159}	Continued From page 16 Intermountain Home Health stated the POC's included much of the same information, and did not appear to be updated to reflect Patient #3's current status, goals, and nursing needs. She stated she reviewed Patient #3's record the evening before, and found the same issues.  The agency failed to ensure an updated, valid, and accurate POC was developed to meet Patient #3's needs.	{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.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure agency staff promptly alerted the physician to changes in patient condition that suggested the need to alter the plan of care for 2 of 10 patients (#6 and #7) whose records were reviewed. This may have resulted in a delay in interventions to address a patient's changing condition who was hospitalized the next day. Findings include:  1. Patient #6 was a 59 year old female admitted to the agency on 5/12/16 for SN and PT services related to CHF. Additional diagnoses included COPD, lupus and HTN. Her record, including the POC, for the certification period 5/12/16 to 7/10/16, was reviewed.  Patient #6's record included an ROC comprehensive assessment dated 6/13/16 and	{G 164}	G 164 Action Plan: 1. Nurse Administrator will educate the staff on when and how to report a change in condition (by providing specific examples) to the physician and the expectation of documentation. This will ensure staff understanding of expectations and knowledge deficits. 2. Nurse Administrator will ensure care coordination discussions take place Monday through Friday for three months, then weekly. Part of the process will be to validate that physician notification has occurred when there is a change needed in the plan of care. Monitoring & Tracking of Compliance: 1. Nurse Administrator will ensure education is documented and that 100% of staff receive education. 2. Nurse Administrator will monitor completion of care coordination meetings. 3. Quality Director or designee will validate that physician communication notes are documented during care coordination meetings for 100% of patients for 4 months, when a change in the POC is indicated, then patient change in condition will be validated on 10% of patients monthly.  8/19/16

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{G 164}	<p>Continued From page 17</p> <p>signed by RN D, her Case Manager. The assessment stated Patient #6 was admitted to the hospital with a diagnosis of heart failure, and was discharged from the hospital on 6/11/16.</p> <p>Patient #6's record included a physician order taken on 6/14/16, and signed by RN D. The order included "Evaluate/Instruct patient/caregiver in weighing daily, recording weight, notifying physician for weight gain greater than 2 pounds in one day or 5 pounds over target weight."</p> <p>Patient #6's record included an SN visit note dated 6/17/16, signed by RN E. The note documented a weight gain of 7 pounds since her last SN visit on 6/13/16. The note did not document communication of Patient #6's weight gain to her physician. Patient #6's record included a "Case Communication Report" dated 6/19/16 and signed by a RN. The report stated Patient #6 was admitted to the hospital on 6/18/16 due to increased edema (excess fluid in the cavities or tissues of the body).</p> <p>During an interview on 6/23/16 at 10:05 AM, Patient #6's RN D stated RN E did not inform her of Patient #6's 7 pound weight gain in 4 days. She stated Patient #6's physician was not notified of her weight gain.</p> <p>The agency failed to alert Patient #6's physician of a signifigant change in her condition.</p> <p>2. Patient #7 was a 53 year old male admitted to the agency on 5/11/16 for SN and PT services for care related to urinary retention. Additional diagnoses included urinary tract infection, constipation, hypoxemia, syncope, collapse, and pneumonia. His record, including the POC, for</p>	{G 164}			

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{G 164}	<p>Continued From page 18</p> <p>the certification period 5/11/16 to 7/09/16, was reviewed.</p> <p>a. The POC included an order for continuous oxygen at 2 LPM. There were no updates or changes to this medication order included in Patient #7's medical record. SN visit notes for 6/01/16 and 6/07/16 documented Patient #7 was using oxygen continuously at 3 LPM. There was no documentation to indicate the physician was alerted to Patient #7's oxygen use that exceeded the orders on the POC.</p> <p>b. A PT "Case Communication Report," dated 6/15/16, included the following note: "call from [name] pta 6/14 - reports pt was taken to ER the day before; pt had apparently blacked out or was unresponsive (no fall had initial episode at home, then another occurrence while at hospital; reported no changes from ER visit, but they recommended f/u with neurologist; pt refused PT; notified hh mgr [home health manager] who will report to visiting nurse." There was no documentation the physician was alerted to Patient #7's ER visit or change in condition.</p> <p>During an interview on 6/23/16 at 8:54 AM, the Director of Quality confirmed the findings. She stated she didn't see any documentation that Patient #7's oxygen use or ER visit had been reported to his physician.</p> <p>SN staff did not alert the physician to Patient #7's oxygen use, and ER visit for a blackout which may have suggested a potential need to alter the plan of care.</p>	{G 164}		
{G 166}	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS	{G 166}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137016	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  R 06/23/2016
NAME OF PROVIDER OR SUPPLIER  INTERMOUNTAIN HOME CARE OF CASSIA			STREET ADDRESS, CITY, STATE, ZIP CODE 1031 E MAIN STREET BURLEY, ID 83318		
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{G 166}	<p>Continued From page 19</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the agency failed to ensure verbal orders were put in writing for 1 of 10 patients (Patient #5) whose records were reviewed. This had the potential to negatively impact coordination and clarity of patient care. Findings include:</p> <p>Patient #5 was a 60 year old male admitted to the agency on 6/17/16 for SN services related to bilateral lower extremity stasis ulcers and cellulitis. Additional diagnoses included HTN, asthma and depression. His record, including the POC, for the certification period 6/17/16 to 8/15/16, was reviewed.</p> <p>Patient #5's record included an SN SOC comprehensive assessment dated 6/17/16 and signed by the Nurse Administrator. The assessment stated the RN contacted Patient #5's physician to obtain orders for his wound care. However, Patient #5's POC did not include wound care orders. A verbal order for his wound care was not documented in his record.</p> <p>During an interview on 6/23/16 at 10:55 AM, the Nurse Administrator reviewed Patient #5's record and stated she forgot to add the wound care orders to his POC. She stated she did not put the</p>	{G 166}	<p>G 166 Action Plan:</p> <ol style="list-style-type: none"> <li>1. Nurse Administrator will educate 100% of the staff that verbal orders are put in writing and signed and dated with the date of receipt. This will ensure clear understanding of verbal order requirements.</li> <li>2. Nurse Administrator will discuss orders in the care coordination meeting and ensure that all verbal orders have been written, signed and dated with the date of receipt. This will ensure that clinicians are following the verbal order requirements.</li> </ol> <p>Monitoring and tracking for compliance:</p> <ol style="list-style-type: none"> <li>1. Nurse Administrator will ensure that 100% of staff is educated and the education is documented.</li> <li>2. Nurse Administrator will validate that verbal orders are documented in patient records during care coordination meetings for 100% of patients for 4 months, then verbal orders will be validated on 10% of patient records monthly.</li> </ol>	8/19/2016	

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{G 166}	Continued From page 20 verbal order in writing to send to Patient #5's physician for signature.	{G 166}			
{G 170}	484.30 SKILLED NURSING SERVICES  The HHA furnishes skilled nursing services in accordance with the plan of care.  This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure skilled nursing services were provided in accordance with the plan of care for 3 of 10 patients (#2, #5, and #7) whose records were reviewed. This had the potential to negatively impact the quality and safety of patient care. Findings include:  1. Patient #2 was a 68 year old male admitted to the agency on 1/22/16 for SN, PT, OT and aide services related to abnormality of gait. Additional diagnoses included heart failure, DM, and 3 pressure ulcers. His record, including the POC, for the certification period 5/21/16 to 7/19/16, was reviewed.  Patient #2's record included a physician's verbal order taken on 5/19/16, and signed by the Physical Therapist. It stated "Nurse visit to administer testosterone injection every 3 weeks, next due week of 5/24/16." Patient #2's record included an SN visit note dated 5/23/16, signed by RNA. The note did not document a testosterone injection was administered. The	{G 170}	Refer to G 158		

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{G 170}	<p>Continued From page 21 next SN visit was documented on 6/16/16.</p> <p>During an interview on 6/23/16 at 11:25 AM, the Administrator of Intermountain Home Health reviewed Patient #2's record and confirmed the SN visit note dated 5/24/16 did not document administration of a testosterone injection. She stated there was no documentation of administration of a testosterone injection during the week of 5/24/16.</p> <p>The SN did not administer Patient #2's injection as ordered by his physician.</p> <p>2. Patient #5 was a 60 year old male admitted to the agency on 6/17/16 for SN services related to bilateral lower extremity stasis ulcers and cellulitis. Additional diagnoses included HTN, asthma and depression. His record, including the POC, for the certification period 6/17/16 to 8/15/16, was reviewed.</p> <p>Patient #5's POC included orders for 1 SN visit on 6/17/16, and 2 SN visits per week for 5 weeks, effective 6/17/16. Three SN visits were ordered for the week of 6/17/16. His record included an SN visit on Friday 6/17/16. No additional SN visits were documented that week.</p> <p>During an interview on 6/23/16 at 10:55 AM, the Nurse Administrator reviewed Patient #5's record. She stated she performed his SOC visit and created the orders on his POC. She stated the SN visit orders were written incorrectly and confirmed Patient #5 did not receive SN visits as ordered on his POC.</p> <p>Patient #5 did not receive SN visits as ordered on his POC.</p>	{G 170}		
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{G 170}	<p>Continued From page 22</p> <p>3. Patient #7 was a 53 year old male admitted to the agency on 5/11/16 for SN and PT services for care related to urinary retention. Additional diagnoses included urinary tract infection, constipation, hypoxemia, syncope, collapse, and pneumonia. His record, including the POC, for the certification period 5/11/16 to 7/09/16, was reviewed.</p> <p>a. The POC included an order for continuous oxygen at 2 LPM. There were no updates or changes to this medication order included in Patient #7's medical record. SN visit notes for 6/01/16 and 6/07/16 documented Patient #7 was using oxygen continuously at 3 LPM. There was no documentation to indicate Patient #7 was re-instructed in the dose that was ordered by the physician.</p> <p>b. An SN visit note, dated 6/07/16, stated "This nurse removed [foley] catheter pt reports he is supposed to arrive at dr visit today with full bladder." There was no documentation physician authorization was obtained prior to the removal of the foley catheter.</p> <p>During an interview on 6/23/16 at 8:54 AM, the Director of Quality confirmed the findings. She stated they should have had range orders for the oxygen to allow variance. She stated she did not see any communication with the physician's office or physician orders for removal of the foley catheter.</p> <p>SN care related to oxygen use and foley catheter removal did not follow a written plan of care for Patient #7.</p>	{G 170}		
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{G 172} {G 172}	Continued From page 23 484.30(a) DUTIES OF THE REGISTERED NURSE  The registered nurse regularly re-evaluates the patients nursing needs.  This STANDARD is not met as evidenced by: Based on review of patient records and staff interview, it was determined the agency failed to ensure the RN comprehensively re-evaluated the nursing needs for 1 of 10 patients (Patient #3) whose records were reviewed. Without a complete assessment, the RN could not accurately identify changing needs for which the physician should be notified and interventions adapted to those needs. Findings include:  Patient #3 was a 7 year old female who was admitted to the agency on 1/17/11, for SN and PT services related to chromosomal abnormalities and an ear infection. Her record, including the POCs, for the certification periods 4/20/16 to 6/18/16, and 6/19/16 to 8/17/16, was reviewed.  1. Patient #3's record included a recertification assessment dated 6/16/16, by her RN Case Manager. The primary diagnosis for both POC's dated 4/20/16 to 6/18/16, and 6/19/16 to 8/17/16, was "Otitis Media"(ear infection). However, the RN who performed the recertification on 6/16/16, did not include documentation of an assessment for present or past ear infections. Additionally, the recertification assessment did not include updated goals and interventions. It was unclear if Patient #3's ear infection was a continuing problem, or if it was resolved.  2. Patient #3's recertification assessment dated	{G 172} {G 172}	G 172 Action Plan: 1. Nurse Administrator will educate 100% of the nursing and therapy staff that a recert visit will include a comprehensive reassessment and documentation will show need for continued home health. This will ensure clear understanding for recert requirements. 2. Nurse Administrator will ensure all recerts are discussed in the care coordination meeting and that there has been a comprehensive assessment performed that identifies a need for continuation of care. Monitoring and tracking for compliance: 1. Nurse Administrator will ensure education is documented and that 100% of staff receive education. 2. Quality Director or designee will audit 100% of all recertifications with 90% accuracy based on the POC auditing tool for four months, then 10% of recertifications will be audited monthly.	8/19/16

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{G 172}	<p>Continued From page 24</p> <p>6/16/16, by the RN Case Manager, did not assess for changes or updates to the "Nursing Diagnosis and Problem List." The "Nursing Diagnosis and Problem List" section of the assessment remained blank.</p> <p>3. Patient #3's recertification assessment dated 6/16/16, by the RN Case Manager, did not include an assessment of goals. The section of the recertification assessment in which the RN was to describe goals, a summary of needs justifying continued home care, teaching needs and discharge planning needs remained blank.</p> <p>During an interview on 6/23/16 beginning at 8:50 AM, the Administrator of Intermountain Home Health reviewed Patient #3's record. She compared the POC for 4/20/16 to 6/18/16, and 6/19/16 to 8/17/16. The Administrator of Intermountain Home Health stated the POC's included much of the same information, and did not appear to be updated to reflect Patient #3's current status, goals, and nursing needs. She stated she had reviewed Patient #3's record the evening before, and found the same issues.</p> <p>Patient #3's RN Case Manager did not perform a comprehensive reassessment of her nursing needs.</p>	{G 172}		
{G 173}	<p>484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>The registered nurse initiates the plan of care and necessary revisions.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it</p>	{G 173}	See next page	

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{G 173}	<p>Continued From page 25</p> <p>was determined the agency failed to ensure the RN initiated or revised the POC for 2 of 10 patients (#6 and #7) whose records were reviewed. This resulted in POCs that did not reflect patient needs and health status. Findings include:</p> <p>1. Patient #6 was a 59 year old female admitted to the agency on 5/12/16 for SN and PT services related to CHF. Additional diagnoses included COPD, lupus and HTN. Her record, including the POC, for the certification period 5/12/16 to 7/10/16, was reviewed.</p> <p>Patient #6's POC for the certification period 5/12/16 to 7/10/16 included orders titled "HOME HEALTH CHF PROTOCOL." The protocol orders included SN visits daily for 3 days, then 3 times a week for 2 weeks to assess for signs of exacerbation of CHF, including a weight gain of 5 pounds in 1 week.</p> <p>Patient #6's record included a ROC comprehensive assessment dated 6/13/16 and signed by RN D. The assessment stated Patient #6 was admitted to the hospital with a diagnosis of CHF, and was discharged from the hospital on 6/11/16. Her home health care was resumed on 6/13/16.</p> <p>Patient #6's record included an update to her POC following her ROC, signed by RN D on 6/14/16. The updated POC did not include the CHF protocol. SN visits were not completed as required under the CHF protocol.</p> <p>Patient #6's record included an SN visit note dated 6/17/16, 4 days after her ROC, signed by RN E. The note documented a weight gain of 7</p>	{G 173}	<p>G 173 Action Plan:</p> <ol style="list-style-type: none"> <li>1. Nurse Administrator will educate 100% of the nursing and therapy staff that plans of care must be updated following significant changes in condition or acute facility inpatient stay. Visit will include a comprehensive reassessment and documentation will show need for continued home health. Plan of care will be updated.</li> <li>2. Nurse Administrator will ensure all patients who have had a significant change in condition or acute facility inpatient stay are discussed in care coordination meetings and that there has been a comprehensive assessment performed including a correlating plan of care.</li> </ol> <p>Monitoring and tracking for compliance:</p> <ol style="list-style-type: none"> <li>1. Nurse Administrator will ensure education is documented and that 100% of staff receive education.</li> <li>2. Quality Director or designee will ensure 100% of all patients who have had significant changes in condition or acute facility inpatient stays in care coordination meetings Monday through Friday for four months, then weekly.</li> </ol>	8/19/16
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{G 173}	<p>Continued From page 26</p> <p>pounds since her last SN visit on 6/13/16. The note did not document communication of Patient #6's weight gain to her physician or RN Case Manager.</p> <p>Patient #6's record included a "Case Communication Report" dated 6/19/16 and signed by RN B. The report stated Patient #6 was admitted to the hospital on 6/18/16 due to increased edema (excess fluid in the cavities or tissues of the body).</p> <p>During an interview on 6/23/16 at 9:50 AM, the Nurse Administrator reviewed Patient #6's record and stated she did not know why the CHF protocol was not initiated following her discharge from the hospital. She stated it was up to the RN's clinical judgement to determine the need for the CHF protocol.</p> <p>The agency failed to ensure Patient #6's POC was updated to meet her needs following her hospitalization.</p> <p>2. Patient #7 was a 53 year old male admitted to the agency on 5/11/16 for SN and PT services. Diagnoses included urinary retention, urinary tract infection, constipation, hypoxemia, syncope, collapse, and pneumonia. His record, including the POC, for the certification period 5/11/16 to 7/09/16, was reviewed.</p> <p>The POC, indicated "SN for foley catheter care." An SN visit note, dated 6/07/16, stated "This nurse removed [foley] catheter pt reports he is supposed to arrive at dr [doctor] visit today with full bladder." An SN visit note, dated 6/21/16, stated Patient #7 "no longer has foley catheter. Urologist's office taught pt how to self-cath."</p>	{G 173}		
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{G 173}	<p>Continued From page 27</p> <p>There was no documentation to indicate the POC was revised to reflect Patient #7's changing status from foley catheter care to self-catheterization, or to assess the patient's knowledge, skill, and infection control techniques in performing self-catheterization.</p> <p>During an interview on 6/23/16 at 8:54 AM, the Director of Quality confirmed the findings. She stated she didn't see documentation of communication with the physician's office regarding the change in status from foley care to self-catheterization care or any verification orders.</p> <p>The RN did not revise the POC to reflect changes in Patient #7's status from foley catheter care to self-catheterization.</p>	{G 173}		
G 176	<p>484.30(a) DUTIES OF THE REGISTERED NURSE</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure the physician was informed of changes in patients' conditions and needs for 2 of 10 patients (#6 and #7) whose records were reviewed. This resulted in missed opportunities for the physician to update plans of care. Findings include:</p> <p>1. Patient #7 was a 53 year old male admitted to the agency on 5/11/16 for SN and PT services for</p>	G 176	Refer to G 143 and G 164	

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G 176	<p>Continued From page 28</p> <p>care related to urinary retention. Additional diagnoses included urinary tract infection, constipation, hypoxemia, syncope, collapse, and pneumonia. His record, including the POC, for the certification period 5/11/16 to 7/09/16, was reviewed.</p> <p>a. Patient #7's POC included an order for continuous oxygen at 2 LPM. There were no updates or changes to this medication order included in Patient #7's medical record. SN visit notes for 6/01/16 and 6/07/16 documented Patient #7 was using oxygen continuously at 3 LPM. There was no documentation to indicate the physician was alerted to Patient #7's oxygen use, which may have indicated a change in patient's condition or needs.</p> <p>b. Patient #7's record included a PT "Case Communication Report," dated 6/15/16, included the following note: "call from [name] pta 6/14 - reports pt was taken to ER the day before; pt had apparently blacked out or was unresponsive (no fall had initial episode at home, then another occurrence while at hospital); reported no changes from ER visit, but they recommended f/u with neurologist; pt refused PT; notified hh mgr [home health manager] who will report to visiting nurse." There was no documentation an RN alerted the physician to Patient #7's ER visit and changing condition.</p> <p>During an interview on 6/23/16 at 8:54 AM, the Director of Quality reviewed Patient #7's record and confirmed the findings. She stated she did not see documentation that the oxygen use had been reported to the physician and it could have indicated an increased need for oxygen. She also stated there should have been a range order</p>	G 176		

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G 176	<p>Continued From page 29</p> <p>obtained for oxygen. She stated she did not see documentation Patient #7's physician was alerted to the ER visit and change in his condition.</p> <p>SN staff did not alert the physician to Patient #7's oxygen use and ER visit for a blackout which may have suggested a need to alter the plan of care.</p> <p>2. Patient #6 was a 59 year old female admitted to the agency on 5/12/16 for SN and PT services related to CHF. Additional diagnoses included COPD, lupus and HTN. Her record, including the POC, for the certification period 5/12/16 to 7/10/16, was reviewed.</p> <p>Patient #6's record included an ROC comprehensive assessment dated 6/13/16 and signed by RN D, her Case Manager. The assessment stated Patient #6 was admitted to the hospital with a diagnosis of heart failure, and was discharged from the hospital on 6/11/16.</p> <p>Patient #6's record included a physician order taken on 6/14/16, and signed by RN D. The order included "Evaluate/Instruct patient/caregiver in weighing daily, recording weight, notifying physician for weight gain greater than 2 pounds in one day or 5 pounds over target weight."</p> <p>Patient #6's record included an SN visit note dated 6/17/16 and signed by RN E. The note documented a weight gain of 7 pounds since her last SN visit on 6/13/16. The note did not document communication of Patient #6's weight gain to her physician or her RN Case Manager.</p> <p>During an interview on 6/23/16 at 10:05 AM, RN D, Patient #6's Case Manager, stated she was not informed of the 7 pound weight gain in 4 days. She stated patient #6's physician was not notified</p>	G 176		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  137016	(X2) MULTIPLE CONSTRUCTION. A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R 06/23/2016
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NAME OF PROVIDER OR SUPPLIER  INTERMOUNTAIN HOME CARE OF CASSIA	STREET ADDRESS, CITY, STATE, ZIP CODE 1031 E MAIN STREET BURLEY, ID 83318
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G 176	Continued From page 30 of her weight gain.	G 176		
G 251	<p>484.52(b) CLINICAL RECORD REVIEW</p> <p>There is a continuing review of clinical records for each 60-day period that a patient receives home health services to determine adequacy of the plan of care and appropriateness of continuation of care.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to review clinical records for each 60 day period a patient received home health services, for 1 of 4 patients (Patient #2) who received services for more than 1 certification period and whose records were reviewed. This had the potential to result in inadequate POCs to meet patients' needs and inappropriate continuation of care. Findings include:</p> <p>1. Patient #2 was a 68 year old male admitted to the agency on 1/22/16 for SN, PT, OT and aide services related to abnormality of gait. Additional diagnoses included heart failure, DM, and 3 pressure ulcers. His record, including the POC, for the certification period 5/21/16 to 7/19/16, was reviewed.</p> <p>Patient #2 was recertified for a 3rd certification period beginning 5/21/16. His clinical record was not accurate to reflect his current condition, care required, and to ensure his needs were met.</p>	G 251	<p>G 251 Action Plan:</p> <p>1. Nurse Administrator will educate 100% of the nursing and therapy staff to recertification requirements. This will ensure clear understanding of appropriateness of continued care.</p> <p>2. Nurse Administrator will ensure all recertifications are discussed and the clinical record reviewed in care coordination meetings and there is an identified need for continuation of care.</p> <p>Monitoring and tracking for compliance:</p> <p>1. Nurse Administrator will ensure education is documented and that 100% of staff receive education.</p> <p>2. Nurse Administrator will audit 100% of all recertifications to ensure 100% were discussed and there is a demonstrated skilled need in the medical record. When 100% compliance is achieved for 4 months, 10% of charts based on average daily census will be randomly audited per quarter.</p>	8/19/16

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G 251	<p>Continued From page 31 Examples include:</p> <p>a. Patient #2's POC for the certification period 5/21/16 to 7/19/16 included primary and other pertinent diagnoses. His diagnoses included 3 pressure ulcers. His POC did not include interventions related to pressure ulcers.</p> <p>Patient #2's record included an OT recertification comprehensive assessment visit note dated 5/20/16, signed by the Occupational Therapist. The assessment stated "Patient has no pressure ulcers."</p> <p>During an interview on 6/23/16 at 11:25 AM, the Administrator of Intermountain Home Health reviewed Patient #2's record and stated he had stage II pressure ulcers during a previous certification period. She stated the pressure ulcers were healed and should not be included as diagnoses on the POC for the certification period 5/21/16 to 7/19/16.</p> <p>b. Patient #2's record, reviewed on 6/22/16, did not include a written summary report (60 day summary) for his previous certification period, which ended on 5/20/16.</p> <p>During an interview on 6/23/16 at 12:00 PM, the Nurse Administrator stated the inaccurate diagnoses, lack of a 60 day summary and missing items on the POC should have been identified during a recertification audit.</p> <p>The agency failed to ensure Patient #2's record was reviewed at the time of his recertification.</p>	G 251		
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{N 000}	16.03.07 INITIAL COMMENTS  The following deficiencies were cited during the state follow-up survey of your agency from 6/22/16 to 6/23/16. The surveyors conducting the follow-up survey were:  Susan Costa, RN, HFS Teresa Hamblin, RN, MS, HFS Kristin Inglis, RN, HFS Nancy Bax, RN, BSN, HFS	{N 000}		
{N 062}	03.07021. ADMINISTRATOR  N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for:  i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur.  This Rule is not met as evidenced by: Refer to G143	{N 062}	Refer to G 143	
{N 091}	03.07024. SK.NSG.SERV.  N091. The HHA furnishes nursing services by or under the supervision of a registered nurse in accordance with the plan of care.  This Rule is not met as evidenced by: Refer to G170	{N 091}	Refer to G 170	
{N 093}	03.07024. SK. NSG. SERV.  This Rule is not met as evidenced by: Refer to G170	{N 093}	Refer to G 172	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Memoria Williams*

*nurse administrator 7/29/16*

Bureau of Facility Standards

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{N 093}	Continued From page 1  N093 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:  a. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs;  This Rule is not met as evidenced by: Refer to G172	{N 093}		
{N 094}	03.07024. SK. NSG. SERV.  N094 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:  b. Initiates the plan of care and makes necessary revisions;  This Rule is not met as evidenced by: Refer to G173	{N 094}	Refer to G 173	
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	N 098	Refer to G 176	

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N 098	Continued From page 2 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 G176	N 098		
{N 152}	03.07030.01.PLAN OF CARE  N152 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:  This Rule is not met as evidenced by: Refer to G158	{N 152}	Refer to G 158	
{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}	Refer to G 159	
{N 155}	03.07030.PLAN OF CARE	{N 155}		

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{N 155}	Continued From page 3  N155 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:  c. Types of services and equipment required;  This Rule is not met as evidenced by: Refer to G159	{N 155}	Refer to G 159	
{N 156}	03.07030.PLAN OF CARE.  N156 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:  d. Frequency of visits;  This Rule is not met as evidenced by: Refer to G158	{N 156}	Refer to G 158	
{N 160}	03.07030.PLAN OF CARE  N160 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:	{N 160}	Refer to G 159	

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{N 160}	Continued From page 4  h. Nutritional requirements;  This Rule is not met as evidenced by: Refer to G159	{N 160}		
{N 161}	03.07030.PLAN OF CARE  N161 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:  i. Medication and treatment orders;  This Rule is not met as evidenced by: Refer to G159	{N 161}	Refer to G 159	
N 168	03.07030.02. PLAN OF CARE  N168 02. Goals of Patient Care. The goals of patient care must be expressed in behavioral terms that provide measurable indices for performance.  This Rule is not met as evidenced by: Refer to G159	N 168	Refer to G 159	
{N 172}	03.07030.06.PLAN OF CARE  N172 06. Changes to Plan. Agency professional staff promptly alert the physician to any changes that suggest	{N 172}	Refer to G 164	

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{N 172}	Continued From page 5 .  a need to alter the plan of care.  This Rule is not met as evidenced by: Refer to G164	{N 172}		
{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 medication and promptly report any problems to the physician.  This Rule is not met as evidenced by: Refer to G166	{N 173}	Refer to G 166	
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:	N 186	Refer to G 145	

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N 186	Continued From page 6 Refer to G145	N 186		