IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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March 3, 2017

Barbara Kirkpatrick, Administrator
North Idaho Home Health
850 W Kathleen Ave
Coeur d'Alene ID 83815

RE: North Idaho Home Health, Provider #137019

Dear Ms. Kirkpatrick:

On February 23, 2017, a follow-up visit of your facility, North Idaho Home Health, was conducted to verify corrections of deficiencies noted during the survey of December 29, 2016.

We were able to determine that the Conditions of Participation of **Organization, Services & Administration (42 CFR 484.14), Acceptance of Patients, POC, Med Super (42 CFR 484.18) and Skilled Nursing Services (42 CFR 484.30)** 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. 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 HHA into compliance, and that the HHA 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.

After you have completed your Plan of Correction, return the original to this office by **March 17, 2017**, 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 RN

DENNIS KELLY, RN, Supervisor
Non-Long Term Care

DK/pmt
Enclosures
ec: CMS Region X Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137019	A. BUILDING _____ B. WING _____	R-C 02/23/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH IDAHO HOME HEALTH	850 W KATHLEEN AVENUE COEUR D ALENE, ID 83815

(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 follow-up Medicare Survey of your agency, conducted from 2/21/17 to 2/23/17. Surveyors conducting the investigation were: Laura Thompson, RN, BSN, HFS, Team Leader Kristin Inglis, RN, HFS Acronyms used in this report include: CHF - Congestive Heart Failure CKD - Chronic Kidney Disease DM - Diabetes Mellitus DON - Director of Nurses EMR - Electronic Medical Record HTN - Hypertension LBS - Pounds LPN - Licensed Practical Nurse MD - Medical Doctor OT - Occupational Therapy POC - Plan of Care PT - Physical Therapy RN - Registered Nurse SN - Skilled Nursing SOC - Start of Care	{G 000}		
{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	{G 158}	Online occurrence submitted for patient#5 identified in the deficiency. Physician notified of reported weight loss and care did not follow the physician's written Plan of Care.	03/10/17 03/10/17

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

Barbara Kirkpatrick | Director of Nurses | 3/15/17

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 158}	Continued From page 1 followed a physician's written POC for 1 of 10 patients (Patient #5) whose records were reviewed. This resulted in the potential for omissions of care and unmet patient needs. Findings include: Patient #5 was an 83 year old male admitted to the agency on 2/14/17, for care related to CHF. Additional diagnoses included HTN, multiple myeloma, peripheral vascular disease, general muscle weakness, and obesity. He received SN, PT, and OT services. His record, including the POC, for the certification period 2/14/17 to 4/14/17, was reviewed. The American College of Cardiology website, accessed on 2/27/17, included patient education entitled "Heart Failure: Checking Your Weight Daily." It stated "A sudden weight gain can mean your heart failure is getting worse." Additionally, it stated "Call your doctor if you notice a sudden weight gain. In general, call if you gain 3 pounds or more in 2 to 3 days." Patient #5's POC included an order for monitoring his weight. It stated "SKILLED NURSE TO OBTAIN WEIGHT EVERY SN VISIT AND NOTIFY RN/MD OF WEIGHT GAIN OR LOSS OF 3LBS OVERNIGHT AND 5LBS ONE WEEK [sic]" Patient #5's weight on his referral order, dated 2/12/17, was 215 pounds. His record included an SN SOC visit note dated 2/14/17, signed by the RN. His weight on his SOC visit was recorded as 222 pounds, a 7 pound weight gain in 2 days. There was no documentation the RN was aware, or had reported the weight gain of 7 pounds in 2 days to Patient #5's physician.	{G 158}	The Director of Nursing (DON) provided education to all clinical staff on policy 2.1.007 Plan of Care and policy 2.1.017 Coordination of Care from Admit Through Discharge. The focus of the education will be regarding review off all current orders before providing care and providing care per those orders. Emphasis will be placed on ensuring Start of Care (SOC) clinician compares weight from referral to Start of Care weight as well as comparing weights on subsequent visits. Any weight gain or loss outside of parameters will be reported to the physician. Education will also be completed on notifying MD when changes occur in the patient's condition. The field clinician will be responsible to review current orders prior to implementation of patient visit. DON/TL will complete a record review of 3 notes per clinician per week to verify care is provided per physician's orders, care coordination occurred, and plan of care complete and accurate.	03/16/17 3/16/17 03/20/17

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{G 158}	Continued From page 2 Patient #5's record included a second SN visit note dated 2/17/17, signed by LPN C. Patient #5's weight was recorded as 209 pounds. There was no documentation in the record of the 11 pound weight loss in 3 days, or that it was reported to the RN or his physician. The RN who performed Patient #5's SOC was no longer with the agency. LPN C was interviewed on 2/22/17 at 2:05 PM. LPN C reviewed Patient #5's record and she stated he was weighing himself and reporting the numbers. She also stated he weighed himself in front of her, and also at night. LPN C stated he was educated to report a "plus or minus of 2 pounds in 24 hours." She also stated she did not check Patient #5's previous weights, and was not aware his weight fluctuated 11 pounds from his SOC visit. The agency failed to follow the POC for Patient #5.	{G 158}	Beginning 3/20/17, DON/Designee will audit 3 CHF patient records weekly to verify the care provided was in accordance with the written Plan of Care to include weight check from referral to SOC and from subsequent visits to ensure the MD is notified when weight gain or loss are outside of parameters. Review will be conducted weekly X 8 weeks and until 100% compliance achieved X 4 consecutive weeks. DON is responsible for implementing the plan of correction.	
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure verbal orders were put in writing by an RN or qualified therapist for 3 of 10 patients (#2, #4, and	G 166	Education provided to all clinical staff by the Director of Nursing (DON) that extenders to include LPN, PTA, and COTA cannot obtain verbal orders per CMS regulation G166. New process was implemented that any observations by an extender that need immediate attention of the physician such as findings outside of parameters, changes in patient condition, or other concerns will be reported to a RN or Qualified Therapist who will then report the findings to the physician and receive a verbal order as applicable. The verbal order will be reduced to writing to the RN and reported back to the LPN, PTA, or COTA.	2/23/17 2/23/17

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G 166	Continued From page 3 #9) whose records were reviewed. This had the potential to negatively impact coordination and clarity of patient care. Findings include: The agency's EMR system included a "Physician Verbal Order" form to record verbal orders obtained from physicians. At the bottom of the form were three signature lines. The first line was for the signature of the staff member taking and entering the order. The second line was for the signature of the person approving and processing the order. The third line was for the physician's signature. 1. Patient #9 was a 96 year old female admitted to the agency on 1/05/16, for care of multiple nonpressure ulcers. Additional diagnoses included Type II DM, edema, dementia, and muscle weakness. She received SN and PT services. Her record, including the POC, for the certification period 12/30/16 to 2/27/17, was reviewed. Patient #9's record included verbal orders obtained, entered, and signed by LPN A on 1/10/17, for wound care. Her record also included verbal orders obtained, entered, and signed by LPN A on 1/27/17, for Coumadin (blood thinner) dosage. 2. Patient #4 was a 91 year old female admitted to the agency on 12/28/16, for treatment of a right buttock pressure ulcer. Additional diagnoses included atrial fibrillation, Type II DM, and hypertensive CKD. She received SN and PT services. Her record, including the POC, for the certification period 12/28/16 to 2/25/17, was reviewed.	G 166	Team Leader will monitor 100% of all orders to ensure that RN, Physical therapist, Speech therapist and Occupational therapist only obtained verbal orders. DON/designee to audit 3 notes per clinician weekly to ensure any observations found by an extender on the visit that needed to be reported to the physician immediately were reported to the a RN or Qualified Therapist who then notified the physician and obtained the verbal order if applicable. Beginning 3/20/17, the DON/Designee will audit 3 patient records weekly to verify that all verbal orders were written by the appropriate discipline. Audit will continue x 8 weeks and until 100% compliance achieved x 4 consecutive weeks. DON is responsible for implementing the plan of correction	2/23/17 2/23/17

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G 166	Continued From page 4 Patient #4's record included verbal orders obtained, entered, and signed by LPN B on 2/10/17, for wound care and PT evaluation. Her record also included verbal orders obtained, entered, and signed by LPN B on 2/17/17, for additional nursing visits. 3. Patient #2 was a 70 year old female admitted to the agency on 2/03/17, for care of a right groin wound after a surgical procedure. Additional diagnoses included primary HTN and a history of falling. She received SN services. Her record, including the POC, for the certification period 2/03/17 to 4/02/17, was reviewed. Patient #2's record included verbal orders obtained, entered, and signed by LPN B on 2/14/17, for wound care. The DON and LPN B were interviewed on 2/22/17 at 8:20 AM. The DON stated LPN's were taking verbal orders, and they were not aware it was against regulations. LPN B confirmed she was taking verbal orders. The agency failed to ensure verbal orders were put in writing by an RN or qualified therapist.	G 166		